

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 18c.		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 9		1 4 3 0 9	
1- STATE REGISTRAR		as		7-16-79		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
SAMUEL KAPLAN						6 23 79		2:40 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		W HITE		MONTH DAY YEAR		75 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		USA				BALTIMORE CITY		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		SINAI HOSPITAL		MANUFACTURER		PLASTIC SIGNS			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
				MARYLAND		BALTIMORE		BALTIMORE	
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13d. INSIDE CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (XXXX)		13e. STREET ADDRESS	
PHILIP KAPLAN				REBECCA		unknown		8420 WINANDS RD. (21208)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		#21208	
NO		217-20-9238		8420 WINANDS RD, Mrs. Maybelle Kaplan, Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Respiratory Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
L629 DUE TO, OR AS A CONSEQUENCE OF <u>Infectious Septicemia</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Col Lung</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Lung</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22</u> , 19 <u>77</u> , to <u>6/23</u> , 19 <u>77</u> , that (I) (we) lost									
saw the deceased alive on <u>6/23</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Gur Charan Arher (9017) M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				6/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Dr GUR CHARAN ADHAR				Sinai Hospital of Baltimore Inc.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL		JUNE 24, 1979		BETH EL		RANDALLSTOWN, MD		BALTO. MD	
24. FUNERAL DIRECTOR		6010 REISTERSTOWN RD.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME SOL LEVINSON & BROS		BALTIMORE, MD. (21215)		JUN 27 1979		Anthony M. Brady			

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 01-10-2001 BY 60322 UCBAW/STP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 1 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETTY JOAN KAUFFMAN			2a. DATE OF DEATH MONTH DAY YEAR JUNE 13, 1979			2b. HOUR 2:15A <sub>M</sub>	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospice			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Hickerson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Hardcastle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 499-62-6681		17. INFORMANT ADDRESS Jerry L. Kauffman, same as line 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ADENOCARCINOMA OF THE COLON WITH METASTASIS 1539 DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c).							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 24, 19 79, to JUNE 13, 19 79, that (I) (we) lost saw the deceased alive on JUNE 13, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE Chergara - Soares, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-13-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. VERGARA-SOARES, M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/18/79		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc., Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE Rickey McBrady	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 1 4 3 1 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNA F. KAUFMAN			2a. DATE OF DEATH MONTH DAY YEAR June 17, 1979		2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 28 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 231 N. ROSE ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FACTORY WORKER		12b. KIND OF BUSINESS OR INDUSTRY CROWN, CORK & SEAL
13a. STATE MD.			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST FRANK MAROUSEK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KONRAD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-12-8958		17. INFORMANT ADDRESS 1903 NORTHBOURNE RD. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the physician) attended the deceased from 2-7, 19 68, to 6-15, 19 79, that (I) (the physician) saw the deceased alive on 6-15, 19 79, and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the physician) did not view the body after death.					
22b. SIGNATURE <i>Melito Torres</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6-18-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MELITO TORRES			22e. ADDRESS 441 S. ELLWOOD AVE.,		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6/21/79	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL HOME NAME SCHEMUNEK FUNERAL HOME, INC.		24b. ADDRESS 3331 BREHMS LANE BALTO. MD. 21213		25a. DATE REC'D. BY REGISTRAR JUN 26 1979	25b. REGISTRAR'S SIGNATURE <i>Jeffrey Halstead</i>

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(M)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 1 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARIE CONSTANCE KEATING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 8 1979</b>			2b. HOUR <b>2:20 AM</b>			
3 SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 4 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>506 WESTGATE RD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES PERSON DEPT. STORE</b>			
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>506 WESTGATE RD</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM J KEATING</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE COUNSELMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-20-4574</b>		17. INFORMANT ADDRESS <b>506 WESTGATE RD</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b> <b>years</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>Jan 70</b> to <b>6/8 79</b> , that (I) <del>was</del> lost saw the deceased alive on <b>5/20 79</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> view the body after death.									
22b. SIGNATURE <b>James Nolan mo</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J J NOLAN</b>			22e. ADDRESS <b>1 Mallow Hill Rd Balt Md 21229</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/11/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>		
24 FUNERAL DIRECTOR NAME <b>WEBER FUNERAL HOME</b>			ADDRESS <b>EDMONDSON AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McBrady</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JESSIE K. KEEFER					JUNE	10	79	3:47	A.M.
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian	MONTH	DAY	YEAR	68	MONTHS	DAYS	HOURS	MIN.
		4	28	11					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
W.VA.	U.S.A.				BALT. CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	UNIV OF MD. HOSPITAL				HOUSE WIFE				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MD	ALLEGANY	Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			438 Seymour St		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
HARRY ROYER		EFFIE E. Cowgill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		219-46-0213		Ruth E. Chaney		LAKELAND Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebrovascular Accident									
4149									
DUE TO, OR AS A CONSEQUENCE OF									
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
CONGESTIVE HEART FAILURE / Pseudomonas Sepsis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
5/16/79		Coronary ARTERY DISEASE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5:51 19 79, to 6:10 19 79, that (I) (we) lost saw the deceased alive on 6/10/19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
GARY A. MANKOWS		MD					6/10/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
GARY A. MANKOWS		UNIV. OF MD. HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		JUNE 13, 1979		Davis Memorial Park		Cumberland Allegany MD.			
24. FUNERAL DIRECTOR'S NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Silcox-Merritt Funeral Service		Cumberland Maryland		JUN 13 1979		[Signature]			

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 1 4

REG. NO.

1. FOR  
STATE  
REGISTER

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Robert P Keller</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 20 79</i>			2b. HOUR <i>10 30 P.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>March 6, 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Charles Gen. Hosp.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>U.S. Post office</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Special Del.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Grover ----- Keller</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillian ----- Downing Downey</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>111-2 212-16-8037</i>		17. INFORMANT ADDRESS <i>Mrs. Ethel M. Keller, Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARCINOMA</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>CARCINOMA of Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6:20 P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>5-7-1979</i> to <i>6-20-1979</i> , that (1) (we) last saw the deceased alive on <i>6-20-1979</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)							
22b. SIGNATURE <i>M.A. Khajawi</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/20/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. A. KHAJAWI</i>		22e. ADDRESS <i>M.D. NORTH CHARLES GENERAL HOSPITAL</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June 25, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemt.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co. Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 22 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia Hebrudy</i>	

14314



1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST LEONARD		MIDDLE E. KELLEY		LAST (KELLY)		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH <input type="checkbox"/> 5		DAY 31		YEAR 1979		2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1920		6. AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 2 1979		2d. HOUR 6p		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17 W. Mulberry St.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Social Sec.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE Maryland				13b. COUNTY <del>xxxxxx</del> Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 17 W. Mulberry St.			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph L. Kelley								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary P. O'Baker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes War II								16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Mr. Leonard D. Kelley, Fla. Son							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: Coronary heart disease

IMMEDIATE CAUSE (a) Congestive heart failure

4280

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) \_\_\_\_\_

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE \_\_\_\_\_ M.D. Assistant MEDICAL EXAMINER DATE SIGNED 6-3-79

EXAMINER'S NAME Ann M. Dixon, M.D. ADDRESS 111 Penn St.  
(TYPE OR PRINT)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	6-14-79	Sunset Memorial Park	Cumberland	Allegany	Md.

24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>JUN 1 1970</b>	25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i>
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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

1841



• *Journal of Management Education* 27(10):1103-1114

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

- 3 -

2544

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14316

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louise Kelley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 15 79</b>		2b. HOUR M <b></b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 16 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>60</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD	
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3027 W. North Ave.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Tom L. Lynch</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della Manley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>223-20-1327</b>		17. INFORMANT ADDRESS <b>Ida Lewis 2911 Westwood Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that this (this hospital) attended the deceased from <b>May</b> , 19 <b>79</b> to <b>JUNE</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased <b>die</b> above, (I) (we) (and) (did not) view the body after death 19 <b>79</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <b>R. Phillips, MD</b>		DEGREE		22c. DATE SIGNED <b>6/20/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. PHILLIPS</b>		22e. ADDRESS <b>UNIV. HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/21/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>

MEDICAL CERTIFICATION

SECRET







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14317

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA G. KELLY			2a. DATE OF DEATH MONTH DAY YEAR 6 1 79			2b. HOUR 11:35P.	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 5 1890		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME & Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PETER J. McENROE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE COOLIHAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. 217-03-8691		17. INFORMANT ADDRESS MARY A. STONER 6502 PARR AVE.					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF COLON WITH METASTASIS 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1979, to June 1, 1979, that (I) (we) last saw the deceased alive on June 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)							
22b. SIGNATURE Walker Impagliatelli				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER IMPAGLIATELLI				22e. ADDRESS CHURCH HOSPITAL, BALTIMORE, MARYLAND			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-5-79		23c. NAME OF CEMETERY OR CREMATORY ST. CHARLES CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO. MD.	
24. FUNERAL DIRECTOR NAME NEWELL F.H.				ADDRESS 1100 REISTERS TOWN RD		25a. DATE REC'D. BY REGISTRAR JUN 5 1979	
				25b. REGISTRAR'S SIGNATURE Rickey McBrady			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 1 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LOUISE R KELLY			2a. DATE OF DEATH MONTH DAY YEAR 6 26 79			2b. HOUR 6:30 AM	
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 11 2 09		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10 CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Gen.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Nero Dawkins			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Sartor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 290-07-5883		17 INFORMANT Marie Boozier		ADDRESS 11 W. 20th St.	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Oat-cell Carcinoma of the lungs 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) with generalized metastases DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/17/1978 to 6/26/1978, that (I) (we) last saw the deceased alive on 6/26/1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE W. D. HARMASANTA			DEGREE MD			22c. DATE SIGNED 6/26/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. D. HARMASANTA			22e. ADDRESS 2724 W. Charles St. Baltimore Md 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/29/79		23c. NAME OF CEMETERY OR CREMATORY BayView Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Jersey City, N.Y.	
24 FUNERAL DIRECTOR NAME Wm C March F/H			ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

SECRET

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(A)

SECRET

Item 5 8333 7/10/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14319

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD T. KELLY</b>		2a. DATE OF DEATH MONTH <b>06</b> DAY <b>17</b> YEAR <b>79</b>		2b. HOUR <b>11:50 PM</b>	
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>July</b> DAY <b>29</b> YEAR <b>1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MARYLAND</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MAINTENANCE</b>
13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3226 AUCHINCLOSS TERR.</b>	
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>ALICE</b> LAST <b>?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>215-16-1861</b>		17. INFORMANT <b>MILLARD SHEPPARD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPALM ARREST</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OBSTRUCTING CA. OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7 MONTHS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>- P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/13</b> 19 <b>77</b> to <b>6/17</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/17</b> 19 <b>79</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Steven H. Resnick</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/17/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN H. RESNICK</b>		22e. ADDRESS <b>UNIV. OF MD. X105P</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-21-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING MEM. PARK</b>	
23d. LOCATION CITY OR TOWN <b>RAWDALLSTOWN MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>		23f. REGISTRAR'S SIGNATURE <b>Ernest H. Hardy</b>	
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT</b> ADDRESS <b>4600 LIB. HOTS. RD.</b>					

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11541 48



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 2 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JESSE J. KENDALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 17, 1979</b>		2b. HOUR <b>6:55P M</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 23 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ga.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Kendall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Howell</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>217-22-5187</b>		17. INFORMANT <b>Rodella Kendall</b>				17. ADDRESS <b>11 W. 20th Street</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>436- Pneumonia</b> IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a), stating the } underlying cause last. } (b) <b>Right Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) }							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 17, 1979</b> , to <b>June 17, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 17, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <b>Renee Waschler</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/17/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Renee Waschler, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	



14320

June 17, 1979

Baltimore City

Maryland General Hospital

I. W. 2000 Bridge

Health

Area

Kennel

Thomas

117-22-107 Robert Kennel

Page

Pneumonia

Right Central Vascular Accident

June 17, 1979

June 17, 1979

June 17, 1979

June 17, 1979

c/o Maryland General Hospital

Robert Kennel, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 3 2 1	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH	DAY	YEAR	2b. HOUR
SOPHIA M. KENNY		6		17		79		4		50am	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
9 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITED		13e. STREET ADDRESS			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT			
Ludwik		Josephine		NO		212-36-6544		Mr. John J. Kenny, 1417 Riverside Ave. Balto.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 410- Cardio Pulmonary Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Central Vascular Accident PROBABLE											
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-16-79 to 6-17-79, that (I) (we) last saw the deceased alive on 6-17-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Andrew Cowley		MD		South Balto Gen. Hosp.		6-17-79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		June 20, 1979		New Cathedral Cemt.		Baltimore, Maryland					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.		JUN 18 1979		Richard A. Cowley							

15241



DHMH-17  
(VR A15 ME (5))  
15M7/76

SSCAI PA



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 2 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John J. KERBER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 12 1979</b>			2b. HOUR <b>10:52A<sub>M</sub></b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 10 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>ARBUTUS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>STEEL CORP. 4727 BELWOOD GREEN, 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN L. KERBER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY A. MURPHY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-09-1007</b>		17. INFORMANT ADDRESS <b>ESTELLE C. NORRIS, 6201 LOCH RAVEN BLVD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Anteroseptal Myocardial Infarction</b> <b>888-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hip Fracture</b>									
19a. DATE OF OPERATION <b>June 5, 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hip Fracture</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:20xx 6 4 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>subject fell ACCIDENT</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>home - Nursing</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>501 W. Mulberry St. Balto. MD</b>					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 4</b> , 19 <b>79</b> , to <b>June 12</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 12</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the <b>June 12</b> , 19 <b>79</b> , and that <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <b>Judy Stone, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-12-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Judy Stone, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>06-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>				ADDRESS <b>21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Estelle C. Norris</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.





June 12 1973 10 22A

RECEIVED

John

Baltimore City

Maryland General Hospital

Baltimore

Acute Intestinal Infection

His Present

June 7 1973

June 12

June 4

June 12

c/o Maryland General Hospital

John Stoen, M.D.



10

9 186 + 16  
KERR JR. REX  
Page 3  
death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 9 1 4 3 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rex D Kerr Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 23, 1979</b>		2b. HOUR <b>6:47pm</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 54</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>25</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Service Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sierra Dodge</b>				
13a. STATE <b>California</b>		13b. COUNTY <b>Tulare</b>		13c. CITY OR TOWN <b>Tulare</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>715 East Inyo</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rex D. Kerr, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bonnie J. Bay</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>557-90-5112</b>		17. INFORMANT ADDRESS <b>Bonnie J. Kerr 715 East Inyo 93274</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5168 IMMEDIATE CAUSE (a) HYPERTENSION, GI BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTERSTITIAL PNEUMONITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE RENAL FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>1 WEEK</b> <b>1 WEEK</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ACUTE MYELOSCLEROSIS, HODGKIN'S DISEASE</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>4/10</b> 19 <b>79</b> to <b>6/23</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/23/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Philip Pulaski</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/23/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Philip Pulaski</b>		22e. ADDRESS <b>Johns Hopkins Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Tulare Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Tulare Tulare Calif.</b>						
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>		24b. ADDRESS <b>Balto., Md. 21236</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		

BP

A S E A I R

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 2 5

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Henry J Kersch</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 18, 1979</b>			2b. HOUR M <b></b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 12, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7004 Old Harford Rd</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fireman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balt. City</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>7004 Old Harford Rd</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Kersch</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary C Seidenzahl</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-30-6806</b>		17. INFORMANT <b>Mrs Anna Kersch</b>		ADDRESS <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CVA stroke</b> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>As hypertensive disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>15 yrs</b>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Hypochyloproteinemia</b>	
19a. DATE OF OPERATION <b>6/18/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hypertension</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7401 Owler Dr Towson, Maryland</b>				
22a. I certify that (I) (the hospital) attended the deceased from <b>1965</b> to <b>6/18/79</b> , that (I) (we) lost saw the deceased alive on <b>4/10/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Joseph D'Antonio M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/19/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph D'Antonio M.D.</b>				22e. ADDRESS <b>7401 Owler Dr Towson, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Kelly</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 2 3 4 5 6



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14326

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH C. KESSLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/22/79</b>		2b. HOUR <b>5:45P</b> M						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 25 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>525 East Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat packer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Packing</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>525 East Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Miller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine R. Herbert</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>187-10-9357A</b>		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypertensive C.V.D.</u> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1-1-24</u> 19 <u>24</u> to <u>6-22</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-13-79</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John Constantine</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6-25-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN CONSTANTINE</b>				22e. ADDRESS <b>234 S. CONKLING ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>6/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert C. Cuddy</i>			



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6/22/79

ELIZABETH C. KESNER

Female

White

USA

X

Balto. City

Balto. City

West Packer

522 East Ave.

Balto.

522 East Ave.

Balto.

Mr.

Element

Cathart

Miller

U.

William

107-10-225A

No

6/22/79

Remove

Balto. Md.

Remove

1 4 3 2 7

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas J. Kesterson</b>		2a. DATE OF DEATH MONTH <b>6</b> / DAY <b>23</b> / YEAR <b>79</b>		2b. HOUR <b>5:50P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>11</b> / DAY <b>30</b> / YEAR <b>99</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS IF UNDER 1 YEAR: MONTHS <b>0</b> / DAYS <b>0</b> IF UNDER 24 HRS: HOURS <b>0</b> / MIN <b>0</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RIGGER</b>		11. KIND OF BUSINESS OR INDUSTRY <b>SHIPBUILDING</b>	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MARYLAND</b> 12b. COUNTY <b>BALTIMORE</b> 12c. CITY OR TOWN <b>ROSEDALE</b>		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS <b>8003 DUVAL AVE.</b>	
14. FATHER'S NAME FIRST <b>---</b> MIDDLE <b>---</b> LAST <b>KESTERSON</b>		15. MOTHER'S MAIDEN NAME FIRST <b>---</b> MIDDLE <b>---</b> LAST <b>---</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WW I</b>	
17. SOCIAL SECURITY NO. <b>219032995</b>		18. INFORMANT <b>RUTH KOHL</b>		19. ADDRESS <b>8003 DUVAL AVE.</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Resp. failure.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ind. stage. Chrt lung disease (or pulmonary).</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>496-</b>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>---</b>					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. <b>---</b> MONTH <b>---</b> DAY <b>---</b> YEAR <b>19</b> P.M. <b>---</b>		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21g. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET <b>---</b> CITY OR TOWN <b>---</b> COUNTY <b>---</b> STATE <b>---</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>6/14/1979</b> to <b>6/23/1979</b> , that (I) (we) lost saw the deceased alive on <b>6/23/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <b>Srinivas</b>		23b. DEGREE <b>---</b>		23c. DATE SIGNED <b>6/23/79.</b>	
23d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SRINIVAS</b>		23e. ADDRESS <b>5601 LOCH RAVEN BLVD.</b>			
24. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		24a. DATE <b>6/26/79</b>		24b. NAME OF CEMETERY OR CREMATORY <b>ZION CHURCH CEMET.</b>	
24c. LOCATION CITY OR TOWN <b>ESSEX</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b>		24d. DATE RECEIVED BY REGISTRAR <b>JUN 27 1979</b>		24e. REGISTRAR'S SIGNATURE <b>---</b>	

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(VRA 15, 4) 7/78

DHMH-16 20M  
(VRA 15, 4) 7/78

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14328

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Roy H. Keys</b>			2a. DATE OF DEATH: MONTH DAY YEAR <b>June 17, 1979</b>		2b. HOUR <b>11:45<sup>a</sup></b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 8 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie M. Keys</b>		13e. STREET ADDRESS <b>2720 N. Howard St.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Maude V. Keys</b>		ADDRESS <b>2720 N. Howard St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma-left lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 15</b> , 19 <b>79</b> to <b>June 17</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 17</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above; <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Helvatore</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/17/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>c/o Maryland General Hospital</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>	
				25b. REGISTRAR'S SIGNATURE <i>Patricia Helvatore</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please allow for retention by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 2 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
LESSIE H. KIMBLETON			6 14 79			P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR		
FEMALE	WHITE	02 28 09	70 YRS.			MONTHS DAYS HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA	U.S.A.		BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	UNION MEMORIAL HOSPITAL			PRACTICAL NURSE			NURSING	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b STATE	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS				
MARYLAND	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	105 W. 39th STREET, 21210					
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME		16 ADDRESS					
SYLVESTER HILL	BETHANY ROSE		RUTH K. BOZEMAN, 4716 GATEWAY TERRACE, 21227					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT						
NO	233-12-2970							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial Infarction								12 hrs.
410- DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Chronic obstructive pulmonary disease								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (this hospital) attended the deceased from 6/14/79, 19 79, to 6/14/79, 19 79, that (I) (we) lost saw the deceased alive on 6/14/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE			DEGREE			22c DATE SIGNED		
Michael N. Rubinstein MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			6/14/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS					
Michael N. Rubinstein			201 E University PKwy					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		23e DATE REC'D. BY REGISTRAR		
BURIAL	06-18-79	WOODLAWN CEMETERY		WOODLAWN BALTIMORE MD.		JUN 15 1979		
24 FUNERAL DIRECTOR NAME			ADDRESS			25b REGISTRAR'S SIGNATURE		
HUBBARD FUNERAL HOME, INC.,			21229 4107 WILKENS AVE.			History Huber		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

P S E A I

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14330

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Father Louis B Kines</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 9 79</i>		2b. HOUR <i>40</i> 12 M					
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 13 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i>		8b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret Religious</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>md.</i>			13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Catonsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Balto, Md. 21228</i> <i>106 Montross Manor Ct</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Louis Kines</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Wanda Ruger</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW1</i>		17. INFORMANT <i>Former Records</i>		ADDRESS <i>St Agnes Hospital</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6-9-79</i> to <i>6-9-79</i> , that (I) (we) last saw the deceased alive on <i>6-9-79 at 1:40 PM</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Prasad Vankimani</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/9/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PRASAD VANKIMANI</i>			22e. ADDRESS <i>900 CATON AVE</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <i>6/13/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodstock Cemt.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodstock Md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto, Md</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Hester McCreedy</i>					

(M)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14331

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROSS I. King			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 6 19 79			7b. HOUR 3:35 P.M.		
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 6-4-1933	6. AGE (IN YEARS) LAST BIRTHDAY 46 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 6 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disable		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2307 Callow Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Ross King Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sisie Mae ? Chew				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219 28 3314		17. INFORMANT ADDRESS Frances King 2307 Callow St.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease

4292 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? (Body only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
(body only)					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 6/7/79	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn Street, Balto. MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-11-79	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Isaiah L. Brown & Son PA 1913 W. Baltimore		25a. DATE REC'D. BY REGISTRAR JUN 11 1979	

1 3 3 4 1 4 7



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*[Faint markings at the top left, possibly "1 3 3 4 1 4 7"]*

*[Faint markings in the middle section, possibly "1 3 3 4 1 4 7"]*

*[Faint markings at the bottom left, possibly "1 3 3 4 1 4 7"]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 3 2

FOR  
STATE  
REGISTER

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Lyndon KIRCHER			2a. DATE OF DEATH MONTH DAY YEAR 6. 3. 79.			2b. HOUR 5:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 17 08		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exterminator		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE Maryland			13b. COUNTY Balto. City		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME George			15. MOTHER'S MAIDEN NAME Erma Jane Morrow		13e. STREET ADDRESS 6307 Moyer Ave. 21206				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1942-1945		17. INFORMANT Eileen Parr		ADDRESS 9508 Fullerdale Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock 7998 DUE TO, OR AS A CONSEQUENCE OF (b) possible Massive MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) or Dissecting thoracic aneurysm 1 hr.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ranjan Sapra					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANJAN SAPRA					22e. ADDRESS Good Samaritan Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/20/79		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR'S NAME J. E. Lowell Lemmon					ADDRESS 10 W. Padonia Rd.		25a. DATE REC'D. BY REGISTRAR JUN 7 1979		
					25b. REGISTRAR'S SIGNATURE Marking McCready				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

14335



14335

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF" are faintly visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9

14333

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>PAULINE KIRKPATRICK</b>			2a DATE OF DEATH MONTH DAY YEAR <b>06 - 09 - 79</b> 2b HOUR <b>849 P</b> M		
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>10 - 14 - 10</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS	7b IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Anne Arundel</b> 13c CITY OR TOWN <b>Linthicum</b> 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS <b>551 First Avenue</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>JAMES OLDAKER</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude TURNER</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>232 24 0741</b>		17 INFORMANT ADDRESS <b>Joseph Kirkpatrick Arnold, 100 Glen Oban Dr. Md. 21012</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure, Congestive Heart Failure</b> <b>2030</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>RENAL FAILURE</b> (c) <b>MULTIPLE MYELOMA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>LEUKOPENIA</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>5-21</b> , 19 <b>79</b> , to <b>6-9</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-9</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Patricia L. Schmoke MD</b> DEGREE <b>MD</b>				22c DATE SIGNED <b>6-9-79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patricia L. Schmoke MD</b>				22e ADDRESS <b>MERCY HOSPITAL</b>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>6/12/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Waldeck Cemetery</b>	
24 FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		24b ADDRESS <b>4001 Ritchie Highway</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Weston W. Virginia</b>	
25a DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>				25b REGISTRAR'S SIGNATURE <i>Patricia Schmoke</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

3 3 3 1 2 2

(M)

Housewife  
John and Anna  
John and Anna

John and Anna  
John and Anna

John and Anna  
John and Anna

John and Anna  
John and Anna

John and Anna  
John and Anna

John and Anna  
John and Anna

John and Anna  
John and Anna

John and Anna  
John and Anna

Item 6 8333 7/10/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14334  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward F. Kirtscher			2a. DATE KNOWN OF DEATH ESTIMATED 6 11 19 79			2b. HOUR 5:50 P M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 29, 1916	6. AGE (IN YEARS) (MONTH DAY) 63 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 6 14 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 416 S. Patterson Park Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Delivery/Sales		12b. KIND OF BUSINESS OR INDUSTRY DAIRY
13a. STATE MD			13b. COUNTY —	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 416 S. PATTERSON PK. AVE.		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kirtscher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cezka Mitzell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WILLI 213-05-6622		17. INFORMANT ADDRESS E.J. KIRTSCHER, 3033 BRADY AVE. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4592 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Virginia L. Dolan MD			TITLE (SPECIFY) Assistant			DATE SIGNED 6/15/79		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/10/79	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION CITY OR TOWN BALTO CO. MD. 21254	STATE
24. FUNERAL DIRECTOR NAME ULCRAH FUNERAL HOME, BALTO. MD 21206			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 1 1979		25b. REGISTRAR'S SIGNATURE Fitzgerald

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 115 ME (5))  
15M 7/76

1 4 2 3 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please make a copy of this certificate and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

166290870

KIRTZ, THEODORE

10



FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THEODORE M. KIRTZ			2a. DATE OF DEATH JUNE 13, 1979			2b. HOUR 8:25A		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 24 29		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) G.M. Plant		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stewart R. Kirtz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marie Schultz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-22-2628		17. INFORMANT 3469 Dunhaven Road Lois J. Kirtz Balto. MD 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis from wound infection</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>586- immunosuppression for renal transplant 2 months</u> and <u>hepatic failure (9/10 hepatitis, HAA+)</u> 1 month								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>UCI bleeding, malnutrition, urine leak from kidney transplant -&gt; wound infection</u>								
19a. DATE OF OPERATION 4/13/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (4/13/79) <u>renal failure, urine leak, persistent leak</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>leak</u>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A				
22a. I certify that (this hospital) attended the deceased from <u>4/13</u> 19 <u>79</u> to <u>6/13</u> 19 <u>79</u> , that (we) lost saw the deceased alive on <u>6/13</u> 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>L.M. Kelly</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/13/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L.M. Kelly				22e. ADDRESS Johns Hopkins Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/16/79		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE <u>Henry K. Kelly</u>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14336

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Joseph G. Kleiderlein								6 19 79		6		19		79		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	white	June 19, 1896		83 YRS						6 20 79		6		20		79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		3501 St. Paul Street		Pipe Fitter		Dupont											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3501 St. Paul Street									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Sophia															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		215-07-3855		Mr. Calvin F. Shilling		16 S. Calvert St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4292		Arteriosclerotic cardiovascular disease															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		chronic alcoholism															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		6/21/79											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Hormez R. Guard, M.D.		111 Penn Street, Balto, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		June 23, 1979		Most Holy Redeemer		Baltimore		Maryland									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Leonard J. Ruck, Inc.		Balto., Md.		JUN 22 1979		L. J. Ruck											

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REG. NO. 14337

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VASILIOS</b>		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		YEAR		2b. HOUR		AM							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>January</b> DAY <b>1</b> YEAR <b>1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. UNDER 24 HRS HOURS <b></b> MIN. <b></b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>545 Valley View Rd.</b>		21204		14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>Klosteridis</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-32-1334</b>		17. INFORMANT <b>Mrs. Stella Varipatis</b>		ADDRESS <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>adenocarcinoma - metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ASCUD</b>																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 24</b> , 19 <b>79</b> , to <b>JUNE 12</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>David Strobel</b> MD										DEGREE		22c. DATE SIGNED <b>6/12/79</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID STROBEL MD</b>										22e. ADDRESS <b>WILKENS &amp; CATON AVE, BALTO. MD. 21220</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 15, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>																	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Balto, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Kennedy</b>															

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THIRD EDITION

THE HISTORY OF THE

UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 14338	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Knight, Elsie						2a. DATE OF DEATH 6 16 79				2b. HOUR 12:04 AM	
3. SEX F		4. RACE Black		5. DATE OF BIRTH 3 19 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2915 Boarman Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST William Richardson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelia Lee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Eunice Gaskins				ADDRESS 2915 Boarman Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Osteosarcoma</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>79</u> , to <u>6/16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jay M Stark MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6/16/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jay M Stark</u>				22e. ADDRESS <u>Sinai Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.					
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony A. Brady</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 3 9

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR 6 17 79		2b. HOUR 11:50 AM	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROME HENRY, KNIGHT		3 SEX MALE		4 RACE WHITE	
5 DATE OF BIRTH MONTH DAY YEAR 2 12 15		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7 UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISTON SALEM, N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH BALTIMORE		10 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO.		11 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE MARYLAND		12b. COUNTY BALTO.		12c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. STREET ADDRESS 410 Oriole Ave.		13b. CITY BALTIMORE		13c. ZIP CODE 21224	
14 FATHER'S NAME FIRST MIDDLE LAST John Walter Knight		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Moser		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II	
16b. SOCIAL SECURITY NO 237-05-8051		17 INFORMANT Thelma L. Knight--Same as 13c		18 ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral acute bronchopneumonia 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Oat cell carcinoma of lung, metastatic DUE TO, OR AS A CONSEQUENCE OF (c) 1 year APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from JUNE 11, 1979, to JUNE 17, 1979, that (I/we) last saw the deceased alive on above, (we) (did) view the body after death.					
22b. SIGNATURE Joan M. Bathon M.D.		DEGREE M.D.		22c. DATE SIGNED 6/18/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joan M. Bathon M.D.		22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/19/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY BALTO.		23f. STATE MD.	
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Dundalk, Md.		25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE P. J. McCreedy	

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) <b>Martha Ann Knoedler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>06-03-79</b>			2b. HOUR <b>12 16A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 21 1939</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>Social Secur.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Abingdon</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3610 Woodsdale Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernhardt Fischer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Davis</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-32-6956</b>		17. INFORMANT <b>Wm. R. Knoedler</b>		ADDRESS <b>Abingdon 3610 Woodsdale Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b> 2040 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a), stating the } underlying cause last. } (b) <b>CYTOSINE ARABINOSIDE THERAPY</b> (c) <b>ACUTE LYMPHOCYTIC LEUKEMIA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Acute Aortic renal failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>4/27/79</b> , 19 <b>79</b> , to <b>6/3</b> , 19 <b>79</b> , that (I) <b>(saw)</b> last saw the deceased alive on <b>6/3</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) <b>(did)</b> <b>(did not)</b> view the body after death.									
22b. SIGNATURE <b>Jeffrey Carter MD</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middle River Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>				ADDRESS <b>7701 Belair Rd</b>		25a. DATE REC'D BY REGISTRAR <b>JUN 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey M. Carter</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7. 9			1 4 3 4 1			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUBIN KOENIGSBERG</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6/28/79</b>			
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 13, 1928</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>51</b>		2b. HOUR <b>325P</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7c. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHEET METAL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>RANDALLSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 204 3926 NOYES CIRCLE</b> #21133	
14 FATHER'S NAME FIRST MIDDLE LAST <b>ELI KOENIGSBERG</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE BRILL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WWII-NAVY 220-20-3360</b>		17 INFORMANT <b>MRS. HARRIET KOENIGSBERG</b> <b>3926 NOYES CIR., APT. 204 RANDALLSTOWN, 21133</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SEPSIS</b> <b>2000</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>GRANDUCYTOPENIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIFFUSE HISTIOCYTIC LYMPHOMA</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>6-28</b> 19 <b>79</b> , to <b>19</b> , that <del>we</del> (we) lost saw the deceased alive on <b>6-28</b> 19 <b>79</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Philip Bronowitz</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PHILIP BRONOWITZ</b>			22e. ADDRESS <b>Sinai Hosp. - Balto, Md 21215</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JULY 1, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PETACH TIKVAH (HAR ZION TIFERETH ISRAEL)</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry Keedy</b>		
6010 REISTERSTOWN RD. BALTO., MD 21215									

MEDICAL CERTIFICATION

1 2 3 4 1 2 3

RECEIVED

RECEIVED

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RECEIVED



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14342

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Douglas		E.		Kohlhoff				DATE ESTI- MATED		6		6		1979		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24. HOUR	
male		white		Sept. 16, 1950		28 YRS.		MONTHS		DAYS		HOURS		MIN.		6		6		1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland		USA				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		University Hospital		Engineer																	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1103 E. Carey St. Balto. Md.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST											
Richard		-----		Kohlhoff		Ruth		-----		Burham											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No		216-52-4420		Mrs. Ann F. Kohlhoff, Same as above																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CRANIO-CEREBRAL INJURY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
8/132		DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF																	
		(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 4:05 A.M. 6 2 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		with horse driver of motorcycle in collision & wagon															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
		street		Ostend St Near Carroll St, Balto.						MD											
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> (HO)		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion													
death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Virginia L. Dolan		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		6/7/79									
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street, Balto, MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE											
Burial		JUN 9, 1979		Glen Haven Mem. Park		Glen Burnie, A. Abo. Maryland															
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
McCully Funeral Home, 130 E. Fort Ave. Balto. Md.		JUN 8 1979		Kistner, Kistner																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 3 4 3

1 DECEASED NAME (TYPE OR PRINT) <b>LEO Charles KOLB</b>			2a DATE OF DEATH MONTH DAY YEAR <b>6 18 79</b>			2b HOUR <b>8<sup>10</sup> AM</b>		
3 SEX <b>MALE</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>8 6 02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSP</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>XXXXXX Manag.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Contin. Can</b>		
13a STATE <b>MD</b>			13b COUNTY <b>XXXXXXX</b>	13c CITY OR TOWN <b>Balt</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <b>524 N. Charles</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Peter Kobylakiewicz</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Rejzner</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>216-10-1774</b>		17 INFORMANT ADDRESS <b>XXXXXX Henrietta Kolb, 524 N. Charles</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest, unknown</b> <b>185-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Metastatic (Bone) Ca Prostate</b> (c) <b>Carcinoma of Prostate</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>3 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>No</b>								
19a DATE OF OPERATION <b>6/14/79</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bony Pain</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from <b>5/27</b> 19 <b>79</b> to <b>6/18</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/18/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.								
22b SIGNATURE <b>Starly B. Silber</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Starly B. Silber</b>				22e ADDRESS <b>333 St Paul Place, Balt Md</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>June 21, 1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Overlea, Balto., Md.</b>		
FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> 6009 Harford Rd., Balto., Md. 21214				25a DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>		

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SECTION 10 OF 10  
10/20/2010 10:11:00 AM

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 4 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>JOSEPH A. KOLODZIEJSKI</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>06 16 79</u>			2b. HOUR <u>2:30 A</u>	
3. SEX <u>MALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>08 - 08 - 1929</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN <u>59</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO CITY</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTO</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SOUTH BALTO GENERAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Delivery Salesman, Oil Co.</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>BALTO</u>		13c. CITY OR TOWN <u>BALTO</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>James --- Kolodziejski</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>JORAN --- ANNA</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>W.W. 2</u>			
16b. SOCIAL SECURITY NO. <u>214-03-1106</u>		17. INFORMANT ADDRESS <u>Mr. Joseph A. Kolodziejski, 216 Meadow Rd. 21225</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>5188</u> IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory distress</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration and status post lobectomy</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>05/14</u> 19 <u>79</u> , to <u>06/16</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>06/16</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. Fleischman</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/16/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Fleischman</u>				22e. ADDRESS <u>South BALTO General Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June, 19, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie, A.A. Co. Maryland</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>McCully Funeral Home, 237 E. Patapsco Ave. Balto. Md. 21225</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1979</u>		25b. REGISTRAR'S SIGNATURE <u>P. H. H. H.</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14345	
1. STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST <b>Joseph Kolorik</b>										MONTH DAY YEAR <b>6 15 79</b>	
3. SEX 4. RACE 5. DATE OF BIRTH 6. AGE (IN YEARS) IF UNDER 1 YR. IF UNDER 24 HRS. 7c. DATE PRONOUNCED DEAD										2b. HOUR	
Male White 5 11 05 74 YRS MONTH DAY YEAR MONTHS DAYS HOURS MIN										10:00 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED WIDOWED DIVORCED										9. BALTIMORE CITY OR COUNTY OF DEATH	
Texas USA										Baltimore City, MD.	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore Maryland General Hospital Cook											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES NO 13e. STREET ADDRESS											
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Joseph Kolorik											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS											
Yes WWII 466-07-1882											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 Bronchopneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Right Cerebral Infarct											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Arteriosclerotic Cardiovascular Disease											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner											
ACTUAL SIGNATURE Virginia L. Dolan M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 6/15/79											
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE											
Removal 6-21-79											
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
Anatomy Board Balto., Md. JUN 27 1979											

[illegible]

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 4 6

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SR <b>LARDNER DORNIN KONE SR</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 23 79</b>				2b. HOUR <b>2:50 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 9 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, Baltimore, Maryland 21218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES LITTLETON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LULA ZINK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 212-09-7527</b>		17. INFORMANT ADDRESS <b>VAMC Medical Records, Baltimore, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatorenal Syndrome</b> <b>5715</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Sepsis</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>June 21</b> , 19 <b>79</b> to <b>June 23</b> , 19 <b>79</b> , that (we) last saw the deceased alive on <b>June 23</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (view the body after death).									
22b. SIGNATURE <b>Steven B. Schwartz, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven B. Schwartz, MD</b>				22e. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/27/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore NationalCemt</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>				ADDRESS <b>6500 York Rd. Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Holroyd</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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West Medical Records, Baltimore, Maryland

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3200 West River Parkway  
Tulhoma, Oregon 97131



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA E. KORYTKOWSKI			2a. DATE OF DEATH MONTH DAY YEAR 6 12 79			2b. HOUR 10 30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 26 83		6. AGE (IN YEARS (LAST BIRTHDAY)) 96 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Char Woman		12b. KIND OF BUSINESS OR INDUSTRY South Baltimore	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 216 East 11th Street	
14. FATHER'S NAME (FIRST MIDDLE LAST) LEONIDOWSKI		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-05-0718	
17. INFORMANT STAN GALT		17. ADDRESS 216 E. 11th St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest 410- DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, Previous CPE X 4 DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial MI.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 6-12-79 to 6-12-79, that (1) we last saw the deceased alive on 6-12-79, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. If (you) (did) (not) view the body after death.							
22b. SIGNATURE H. Anderson		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-12-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Anderson		22e. ADDRESS South Baltimore Gen Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-15-79		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Charles L. Steyer		ADDRESS 1501 E. Fort Ave		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

14841 8A



# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

7 9 1 4 3 4 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Robert.</b>		FIRST <b>Kritchlin</b>		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a UNDER 1 YEAR		7b UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>city</b>					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>MD</b> 13c COUNTY <b>Baltimore</b> 13d CITY OR TOWN		13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f STREET ADDRESS <b>2235 Southland Ad</b>							
14 FATHER'S NAME FIRST <b>Ronald</b> MIDDLE <b>Kritchlin</b> LAST		15 MOTHER'S MAIDEN NAME FIRST <b>Molly</b> MIDDLE <b>Adams</b> LAST									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral bleed.  
2396  
DUE TO, OR AS A CONSEQUENCE OF -  
(b) Brain tumor  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Bone Marrow suppression

19a DATE OF OPERATION <b>16 March 79</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain tumor</b>		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>6/22</u> 19 <u>79</u> to <u>6/28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

23a SIGNATURE <u>Roberto Bellegarriue</u>		DEGREE <b>MD</b>		22c DATE SIGNED <b>6/28/79</b>	
23b PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roberto Bellegarriue</b>		22d ADDRESS <b>Mercy Hospital</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>6-30-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore</b>	
24 FUNERAL DIRECTOR NAME <b>Stansbury Funeral Home</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>		25a DATE REC'D. BY REGISTRAR <b>JUL 5 1979</b>		25b REGISTRAR'S SIGNATURE <b>Henry McBrady</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 4 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Michael KROPP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 8 1979</b>		2b. HOUR <b>7:35A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 15, 1912</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>8040 Lansdale Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Michael Kropp</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary F. Dixon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. WW <b>11</b>	16c. SOCIAL SECURITY NO. <b>216-01-3516</b>	17. INFORMANT ADDRESS <b>Mrs. Mary Kropp 8040 Lansdale Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <del>xxx</del> hospital attended the deceased from <b>May 14</b> , 19 <b>79</b> , to <b>June 8</b> , 19 <b>79</b> , that <del>x</del> (we) lost <del>the</del> deceased alive on <b>June 8</b> , 19 <b>79</b> , and that in <del>xxx</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(we)</del> (did) <del>(xxx)</del> view the body after death.					
22b. SIGNATURE <b>Marc S. Kallins M.D.</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-8-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marc S. Kallins, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6-11-1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>	

BP

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June 8 1979 7:32

KNOW

George

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Baltimore City

Maryland General Hospital

Bellevue

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Metropolitan Police

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6-8-79

c/o Maryland General Hospital

W.C. Kallman

6

-PAGE 5-



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 14350				
1. FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	MIN.
XX ELVA V. KUPFER								JUNE 22, 1979					10:30	A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS.		9. UNDER 24 HRS.		
FEMALE		WHITE		5 21 1909		70		MONTHS		DAYS		HOURS		MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		U.S.A.				BALTIMORE CITY MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF KNOWN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE		CHURCH HOSPITAL		HOMEMAKER										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		937 S. BELNORD AVE						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST				
WILLIAM A. GRIFFITH		FLORENCE CHAMBERLAIN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO		214 20 7873		GEORGE KUPFER JR.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5570 MESPENTERIC THROMBOSIS														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
6-21-79		MESENTERIC THROMBOSIS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		HOUR A.M. MONTH DAY YEAR												
		P.M. 19												
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>														
22. I certify that (1) (this hospital) attended the deceased from JUNE 20, 1979, to JUNE 22, 1979, that (1) (we) last saw the deceased alive on JUNE 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)														
22a. SIGNATURE		DEGREE		22b. ADDRESS		22c. LOCATION		22d. DATE						
Y. K. SHETTY		M.B.B.S.		CHURCH HOSPITAL CORPORATION		BALTIMORE MD		6-22-79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Y. K. SHETTY		100 N. BROADWAY, BALTIMORE, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE				
BURIAL		6 25 1979		HOLY REDEEMER		BALTIMORE MD		JUL 3 1979		Raymond L. Kaczorowski				
24. FUNERAL DIRECTOR		24b. ADDRESS												
NAME		ADDRESS												
Raymond L. Kaczorowski		5525 FLEET												

14320

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF OF BUREAU

FAMILY UNIT 1911

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

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UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 5,6 g533 7/9/79 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14351

1. DECEASED NAME (TYPE OR PRINT) ALFRED HENRY KUREK		2a. DATE OF DEATH 6/20/79		2b. HOUR 11 P.M.	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH 01 DAY 22 YEAR 1925	6 AGE (IN YEARS LAST BIRTHDAY) 54-55 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELEC. ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY G.I. MARTIN
13a. STATE MARYLAND		13b. COUNTY CARROLL	13c. CITY OR TOWN UNION BRIDGE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RT. #1, BUNKER HILL ROAD
14 FATHER'S NAME FIRST PETER MIDDLE KUREK LAST		15. MOTHER'S MAIDEN NAME FIRST STELLA MIDDLE DRASKIEWIECZ LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 212-22-3675	17 INFORMANT ADDRESS UNION BRIDGE, MD. JEAN KUREK, RT. #1, BUNKER HILL ROAD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetic Nephropathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pericarditis - # A160</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>6/12/79</i> , 19 <i>79</i> , to <i>6/20/79</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/12/79</i> , 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Robert I Levy</i>		DEGREE		22c. DATE SIGNED <i>6/21/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert I Levy</i>		22e. ADDRESS <i>Sinai Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 06-23-79	23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.,		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JUN 22 1979	25b. REGISTRAR'S SIGNATURE <i>Robert A. Brady</i>

BP

1 2 2 4 1 8 8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 5 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARIE M. KWIATKOSKI</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JUNE 15 1979</b>		2b HOUR <b>5:08 AM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>July 11, 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		10 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MARYLAND GENERAL HOSPITAL</b>			
11a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 11a STATE <b>Maryland</b> 11b COUNTY <b>Baltimore</b> 11c CITY OR TOWN <b>Baltimore</b> 11d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Howsewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a FATHER'S NAME FIRST MIDDLE LAST <b>Frederick King</b>		14 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Fegelein</b>			
15a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		15b SOCIAL SECURITY NO. <b>215-05-1738</b>		16 INFORMANT ADDRESS <b>Frank Kwiatkoski 3630 E. Fayette Street</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>
2898 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ACUTE MALIGNANT MYELOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)		<b>ONE YEAR</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (this hospital) attended the deceased from <b>JUNE 14 1979</b> to <b>JUNE 15 1979</b> , that (we) last saw the deceased alive on <b>JUNE 15 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.			
22b SIGNATURE <b>Renee Waschler</b>		22c DATE SIGNED <b>6/15/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>RENEE WASCHLER M. D.</b>		22e ADDRESS <b>c/o MARYLAND GENERAL HOSPITAL</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>6-18-1979</b>	23c NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>
24 FUNERAL DIRECTOR FIRM <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Avenue</b>		25a DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>	25b REGISTRAR'S SIGNATURE <b>Robert McBrady</b>



1 4 3 2 3

JUNE 12 1972 12:00 A

ADMITTING

NAME

BALTIMORE CITY

MARYLAND GENERAL HOSPITAL

BALTIMORE

1111 J. Edgar Hoover

Room 1111

Room 1111

Room 1111

1111 J. Edgar Hoover

MINUTES

CARDIOVASCULAR ARREST

ONE YEAR

MUTE BILIGUANT MYOCLEROSIS

1

JUNE 12 1972 12:00 A

ADMITTING

NAME

C/O MARYLAND GENERAL HOSPITAL

RENEE MARSHALL N. D.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 4 3 5 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WANDA J. LAING			2a. DATE OF DEATH MONTH DAY YEAR 06-24-79		2b. HOUR 4:50 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-4-37		6. AGE (IN YEARS LAST BIRTHDAY) 41	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good SAMARITAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control		12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING
13a. STATE W. VA.		13b. COUNTY Berkeley	13c. CITY OR TOWN Hedgesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. #4 Box 581
14. FATHER'S NAME FIRST MIDDLE LAST JACOB - - - MYERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMANDA - - - KITCHEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No	
16b. SOCIAL SECURITY NO 236-54-8587		17. INFORMANT Dennis R. Laing		ADDRESS Rt. 4 Hedgesville	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) 4460 Respiratory failure	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Polyoarthritis nodosum	6 mos
DUE TO, OR AS A CONSEQUENCE OF (c) Probable pancreatitis	2 days

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION June 19, 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypertension		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from June 19, 1979, to June 24, 1979, that (I) (we) last saw the deceased alive on June 24, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Douglas Union	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED June 24, 79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS KWON	22e. ADDRESS GOOD SAMARITAN HOSP. BALTIMORE		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6-26-79	23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory	23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV
24. FUNERAL DIRECTOR NAME Brown Funeral Home		25a. DATE REC'D. BY REGISTRAR JUN 28 1979	25b. REGISTRAR'S SIGNATURE History/Calvin

1 4 2 2 2



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 5 4

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JOSEPH LAMPKIN		JUNE 18, 1979		1:45A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Black	July 21, 1956	22	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Mississippi	U.S.A.		BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	THE JOHNS HOPKINS HOSPITAL		None		None
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Miss.		Hinds	Jackson	1330 Deer Park	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Willie LAMPKIN		Vanola INGRAM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT (Mother) ADDRESS		
No		428-08-1240	Mrs. Vanola Lampkin Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2849 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>GRAM-NEGATIVE SEPSIS</u>					12 HRS
DUE TO, OR AS A CONSEQUENCE OF (c) <u>APLASTIC ANEMIA</u>					24 HRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ACUTE RENAL FAILURE</u>					4 MONTHS
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9</u> 19 <u>79</u> , to <u>6/18</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) did not see the body after death)					
22b. SIGNATURE <u>Daniel T. McClenathan</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>6/18/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANIEL T. MCCLENATHAN</u>		22e. ADDRESS <u>550 N. BROADWAY BALTIMORE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/24/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Raymond Miss. Cem.</u>	
				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hinds Miss.</u>	
24. FUNERAL DIRECTOR NAME <u>E. Barnes Fleming Funeral Service</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 21 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>	

BP



4 3 2 1

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

NAME	Mr. J. Edgar Hoover
DATE	July 21, 1964
TO	Director, FBI
FROM	Mr. J. Edgar Hoover
SUBJECT	Internal Security - Communist
RE	NY 100-100000
INFO	NY 100-100000
ATTN	Mr. J. Edgar Hoover
FILE	NY 100-100000
CLASS	NY 100-100000
INDEX	NY 100-100000
SEARCHED	NY 100-100000
SERIALIZED	NY 100-100000
FILED	NY 100-100000
APPROVED	NY 100-100000
SPECIAL AGENT IN CHARGE	NY 100-100000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 5 5

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST ROSE	MIDDLE C.	LAST LANCASTER	2a. DATE OF DEATH MONTH JUNE	DAY 4	YEAR 1979	2b. HOUR 6:34 P
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 09 04 04		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2698 DULANY STREET, 21223		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. LANCASTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE HOFFMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 212-10-4873		17. INFORMANT ADDRESS CATHERINE HYNES, 2696 DULANY STREET, 21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PONTINE HEMORRHAGE</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 12 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1979</u> to <u>June 4, 1979</u> , that (I) (we) last saw the deceased alive on <u>June 4, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
27b. SIGNATURE <u>C. d'Arcangues</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				27c. DATE SIGNED 6/4/79		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) C. d'ARCANQUES		27e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-08-79		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND				
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.		ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR JUN 6 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VR A 15 (4)) 9/74

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 5 6

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Stephen	MIDDLE A.	LAST LANCASTER	2a. DATE OF DEATH MONTH DAY YEAR 6 16 79		2b. HOUR 1:00 P.M.	
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 21 79		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.B.G.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8412 Lockwood Road		
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN KLANCASTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEONA MAYDEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Father - same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac respiratory arrest</u> 7469 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congenital heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>5.21.1979</u> to <u>6.16.1979</u> , that (I) (we) lost saw the deceased alive on <u>6.16.1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE G. J. Yeganeh				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUILTY YEGANEH				22e. ADDRESS South Baltimore General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 19 June 79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md.				
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE Dorothy McLeod				

MEDICAL CERTIFICATION

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 5 7

1. DECEASED NAME (TYPE OR PRINT) ANNA M. LANGREHR			2a. DATE OF DEATH MONTH DAY YEAR 06/25/79		2b. HOUR 11:15 P.M.						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 4, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
13. CITY OR TOWN OF DEATH BALTIMORE		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		16. KIND OF BUSINESS OR INDUSTRY Home			
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland 17b. COUNTY - 17c. CITY OR TOWN Baltimore		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS 3119 Pelham Avenue 21213							
20. FATHER'S NAME FIRST MIDDLE LAST Louis Riebold			21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Zimmerman								
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			23. SOCIAL SECURITY NO 214-01-5650			24. INFORMANT ADDRESS Marie Kesting (dgtr) same as 13					
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Massive CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): -											
26. DATE OF OPERATION -			27. CONDITION FOR WHICH OPERATION WAS PERFORMED -			28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19								
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -			34. LOCATION STREET CITY OR TOWN COUNTY STATE - Baltimore					
35. I certify that (this hospital) attended the deceased from <u>06/18</u> , 19 <u>79</u> , to <u>06/25</u> , 19 <u>79</u> , that (we) last saw the deceased alive on <u>06/25</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
36. SIGNATURE <u>Gregory J. Walker</u> MD			37. DEGREE MD			38. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			39. DATE SIGNED 06/25/79		
40. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY WALKER			41. ADDRESS UNION MEMORIAL HOSPITAL								
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			43. DATE 6/29/79		44. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.			45. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
46. FUNERAL DIRECTOR Name Scamonek Funeral Home, Inc.			47. ADDRESS 3331 Brehms Lane Balto. Md. 21213			48. DATE REC'D BY REGISTRAR JUN 26 1979			49. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

1 2 3 4 1 0 1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14358

1- STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Adelaide Lantz</b>			2a DATE KNOWN OF DEATH MONTH DAY YEAR <b>6 16 19 79</b>			2b HOUR M <b>10:14</b>		
3 SEX <b>female</b>	4 RACE <b>white</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>DEC. 8, 1905</b>	6 AGE (IN YEARS) LAST BIRTHDAY <b>73</b> YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 16 19 79</b>	7d HOUR M <b>10:14</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospita</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE <b>MD.</b>		13b COUNTY <b>-----</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>DENNIS W. DAVIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATTIE JOHNSON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-24-8492</b>		17. INFORMANT ADDRESS <b>800 COCONUT CT. APT. K BELAIR, 21014, MD.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: **Ruptured abdominal aortic aneurysm**

IMMEDIATE CAUSE (a) **4413**  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b)   
(c)   
DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a DATE OF OPERATION  
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?  
(BODY ONLY)  
YES ☒ NO ☐

20a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
20b TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19  
20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
20d PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
20e LOCATION  
STREET CITY OR TOWN COUNTY STATE  
(Body Only)

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Virginia L. Dolan** M.D. TITLE (SPECIFY) **Assistant** DATE SIGNED **6/17/79**  
EXAMINER'S NAME (TYPE OR PRINT) **Virginia L. Dolan, M.D.** ADDRESS **111 Penn Street, Balto., MD 21201**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b DATE <b>6-20-79</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEM.</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>5501 FREDERICK AVE. BALTO., MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lehman S. Geller &amp; Son, Inc.</b>		25a DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>	25b REC'D. BY REGISTRAR <b>[Signature]</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14359

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNIE M. LAPRADE			2a. DATE OF DEATH MONTH DAY YEAR 6-18-79			2b. HOUR M M	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 5 1901		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2346 McCulloh Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William Parrish		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Gent		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Alberta Brown 2346 McCulloh Street					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4039 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension (c) Chronic Renal Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-19 1979 to 6-13 1979, that (I) (we) last saw the deceased alive on 6-13 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. O. Crosley				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. O. Crosley				22e. ADDRESS 936 W. North Ave Baltimore			

23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 6-22-79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Maryland	
24 FUNERAL DIRECTOR NAME William C. Brown Mortuary				ADDRESS 1206-08 West North Ave		25a. DATE REC'D. BY REGISTRAR JUN 21 1979	
						25b. REGISTRAR'S SIGNATURE Dorothy McBrady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 2 5 4 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (S))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14360

1- FOR STATE REGISTRAR		2- DATE KNOWN OF DEATH		3- MONTH		4- DAY		5- YEAR		6- HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH		7b. HOUR	
Paul Don Laury								6 10 19 79		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	7a. DATE KNOWN OF DEATH	7b. HOUR						
Male	Black	MONTH DAY YEAR	LAST BIRTHDAY YRS.	MONTH DAY YEAR	3:50 PM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
	United States			Baltimore City, MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore	601 Light Street (in police boat)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2834 Presbury Street							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
		218-42-3683									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Drowning</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <u>984-</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR		Subject found floating in water							
		? P.M. 6 10 19 79									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				STATE			
		water		Chesapeake Bay, Inner Harbor, Baltimore				Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED					
Virginia L. Dolan MD		Assistant				6/15/79					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Virginia L. Dolan, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Removal		7/5/79				CITY OR TOWN					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS		JUL 11 1979		L. J. Brady							
Anatomy Board		Balto., Md.									

1506 BP

00241-1



Remove 1/27/79

Delco. Co.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 6 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES T LAWRENCE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 24 79</b>		2b. HOUR <b>12:00 AM</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 17 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD		
10. CITY OR TOWN OF DEATH <b>BALTO</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CITY HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>DUNDALK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1 SEABRIGHT AVE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES LAWRENCE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>UNK</b>		16b. SOCIAL SECURITY NO <b>213 071690</b>		17. INFORMANT ADDRESS <b>JOHN R. LAWRENCE ABOVE</b>		
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIO - PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Leo J. Spaccavento MD</b>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEO J. SPACCAVENTO</b>				22e. ADDRESS <b>BEL</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>J. G. CONNELL 300 MACE</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		
25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>						

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (3))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14362

1. FOR STATE REGISTRAR									
2a. DECEASED NAME (TYPE OR PRINT) <b>Brian Eugene Leader</b>									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/13/1959</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>19</b>		7a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 17 19 79</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		24. HOUR <b>10:27 a</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tool Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tool &amp; Die</b>	
13a. STATE <b>Penna.</b>		13b. COUNTY <b>York</b>		13c. CITY OR TOWN <b>York</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3700 W. Market St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Leader</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lorraine Moody</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>184-46-0643</b>		17. INFORMANT ADDRESS <b>Mrs. Lorraine Leader, Stewartstown, Pa. 17363</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>8:25xx 6 17 1979</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>passenger in auto/fixed object impact</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 32 north of Rt. 26 Carroll, MD.</b>			
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Margareta A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>6/18/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery Loganville, York Co., Penna.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <b>Kenneth W. Osburn</b>				ADDRESS <b>Stewartstown, Pa. 17363</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

NO 14305





#6, Film G532 6/28/79 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 4 3 6 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph V. Leake</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 15, 1979</b>		2b. HOUR A <b>11:00</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 1, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 - 73 -</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Pimlico</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3032 Grantley Avenue 21215</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dental Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto. City</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Leake</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna (Unknown)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-07-4991-A</b>		17. INFORMANT <b>Mrs. Gladys Leake</b> <b>3032 Grantley Ave. Balto. Md. 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>515-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral pulmonary fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>xxx</del> attended the deceased from <b>November</b> 19 <b>68</b> to <b>May</b> 19 <b>69</b> , that (I) <del>xxx</del> lost saw the deceased alive on <b>May 19, 1979</b> , and that in (my) <del>xxx</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>xxx</del> (did) view the body after death.					
22b. SIGNATURE <i>Millard Traband</i>				22c. DATE SIGNED <b>6/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Millard Traband</b>				22e. ADDRESS <b>1811 North Rolling Road</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, PA.</b> <b>8728 Liberty Road Randallstown, Md. 21133</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>				25b. REGISTRAR'S SIGNATURE <i>Robert A. Brady</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
FOR Items 18a. 1. STATE REGISTRAR <b>Film#G533</b> <b>7-16-79</b>																	
1. DECEASED NAME (TYPE OR PRINT) <b>Bernard Taylor Lee</b>																	
2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>6</b> YEAR <b>19 79</b>																	
3. SEX <b>male</b>																	
4. RACE <b>black</b>																	
5. DATE OF BIRTH MONTH <b>9</b> DAY <b>16</b> YEAR <b>1915</b>																	
6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS. <table border="1"> <tr> <td>IF UNDER 1 YR.</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>MONTHS</td> <td>DAYS</td> </tr> <tr> <td></td> <td>HOURS</td> </tr> <tr> <td></td> <td>MIN.</td> </tr> </table>										IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS		HOURS		MIN.
IF UNDER 1 YR.	IF UNDER 24 HRS.																
MONTHS	DAYS																
	HOURS																
	MIN.																
7c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>6</b> YEAR <b>19 79</b>																	
7d. HOUR <b>4:47</b> P.																	
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>																	
7f. CITIZEN OF WHAT COUNTRY? <b>USA</b>																	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>																	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.																	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>																	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1420 E. Fairmount Avenue</b>																	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>																	
12b. KIND OF BUSINESS OR INDUSTRY																	
13a. STATE <b>Maryland</b>																	
13b. COUNTY																	
13c. CITY OR TOWN <b>Baltimore, M.d.</b>																	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
13e. STREET ADDRESS <b>1420 E. Fairmount Ave.,</b>																	
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE LAST <b>Lee</b>																	
15. MOTHER'S MAIDEN NAME FIRST <b>Clara</b> MIDDLE LAST <b>Smith</b>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>																	
16b. SOCIAL SECURITY NO. <b>Unknown</b>																	
17. INFORMANT ADDRESS <b>Brandford Lee Rt., 1, New Canton, Va.</b>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease with</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>recent right cerebral infarct.</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION																	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																	
20. AUTOPSY? (Head Only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>																	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
22b. Autopsy <input checked="" type="checkbox"/> HO Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D. <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>6/7/79</b>																	
EXAMINER'S NAME <b>Virginia L. Dolan, M.D.</b> ADDRESS <b>111 Penn Street, Balto., MD 21201</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>																	
23b. DATE <b>6-18-79</b>																	
23c. NAME OF CEMETERY OR CREMATORY <b>New Hope Ch. Cem.,</b>																	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Buckingham Co., Va.,</b>																	
24. FUNERAL DIRECTOR NAME <b>C. Stokes</b> ADDRESS <b>Bland-Reid Funeral Home Farmville, Va. 23901</b>																	
25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>																	
25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>																	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14365

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6 22 79		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		5 10 10		69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Va.		USA				Balto. City MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		2405 Brookfield Ave.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Alfred		Kate		No		217-01-3557	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Amanda May Lee		2405 Brookfield Ave.		IMMEDIATE CAUSE (a) <u>unknown</u>			
				DUE TO, OR AS A CONSEQUENCE OF			
				(b) <u>Metastatic lung cancer</u>		3 months	
				DUE TO, OR AS A CONSEQUENCE OF			
				(c) <u>Prolonged cigarette abuse</u>		40 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> , 19 <u>79</u> , to <u>6/19</u> , 19 <u>79</u> , that (I) (we) last saw the deceased <u>above</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>James L. Abbuzzese</u>		M.D.				6/26/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
James L. Abbuzzese		John Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		6/27/79		Arbutus Mem. Pk.		Arbutus, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		JUN 27 1979		<u>Patrick K. Kennedy</u>			
Wm C March F/H		1101 E. North Ave.					

20041-91

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.3  
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 6 6

1. DECEASED NAME (TYPE OR PRINT) <b>WARD LEE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6-1-79</b>		2b. HOUR <b>1:30 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 23, 1907</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>71 YEARS</b>		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>		9b. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>		9c. MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOILER MAKER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>LOCAL 193</b>		13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>	
13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4336 ELDONE ROAD 21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DORSEN LEE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY CUNNINGHAM</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>270-05-0856</b>		17. INFORMANT <b>MRS. LILLIAN A. LEE, 4336 ELDONE ROAD</b>		ADDRESS <b>21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stroke (appt)</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ <b>Cystitis</b>					
19a. DATE OF OPERATION <b>6-1-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cystitis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <b>3-15-79</b> to <b>6-1-79</b> , that (X) (we) lost saw the deceased alive on <b>6-1-79</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>G. Culhota</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-1-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIL MAHOTRA</b>		22e. ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD. 21229</b>		23e. DATE REC'D. BY REGISTRAR <b>JUN 4 1979</b>		23f. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>					

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BALTIMORE CITY

ST. JAMES HOSPITAL

BALTIMORE

00 CATON A.M. BALTIMORE, MD. 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 6 7

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie Elizabeth Lehnhoff			2a DATE OF DEATH MONTH DAY YEAR 6 12 79 4A <sup>50</sup> M	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Dec. 26, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 82
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD
10 CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinner Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Home-
13a STATE MD		13b COUNTY Baltimore	13c CITY OR TOWN 21234	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Conrad Polk		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Michael		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-01-9753d		17 INFORMANT ADDRESS W. Leroy Lehnhoff 11 Ruxview Ct.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C-R failure</u> 4289 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Agarwal MD 22c DATE SIGNED 6/12				
22d PHYSICIAN'S NAME (TYPE OR PRINT) ASHOK AGRAWAL		22e ADDRESS Sinner Hosp.		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/15/79		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley
23d LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.				
24 FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd.		25a DATE REC'D. BY REGISTRAR JUN 13 1979		25b REGISTRAR'S SIGNATURE H. J. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Items 21a thru 21f.

1- FOR STATE REGISTRAR 22a. 535 9/11/79 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 6 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ROSE			2a DATE OF DEATH MONTH DAY YEAR 6/16/79			2b HOUR 4:00 PM		
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR OCT. 22 1892		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10 CITY OR TOWN OF DEATH BALTO.	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY HOME		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.			13b CITY OR TOWN BALTO.			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST HENRY ROLF			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA ERNST			16a ADDRESS 3635 DUDLEY AVE.		
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16c SOCIAL SECURITY NO. 212-50-5926			17 INFORMANT MILDRED RAVEN (DGHTR)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY 436- IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured Left H.R. DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a DECEASED WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 6/13/79 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fell at home, brought to E.R. - Fractured left hip			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f LOCATION STREET CITY OR TOWN COUNTY STATE 3658 Kenyon Ave., Balto., Md. 21213		22a I certify that (I) (this hospital) attended the deceased from 6/16/79 to 6/16/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b SIGNATURE B.K. Yorkoff MD			22c DATE SIGNED 6/16/79			22d PHYSICIAN'S NAME (TYPE OR PRINT) Yorkoff		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 6/19/79		23c NAME OF CEMETERY OR CREMATORY BALTIMORE		23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24 FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC.			24b ADDRESS 3233 BREHMS LANE BALTO. MD. 21213		25a DATE REC'D. BY REGISTRAR JUN 26 1979		25b REGISTRAR'S SIGNATURE [Signature]	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 6 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph L. Leitzer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 9, 1979</i>		2b. HOUR <i>1:25 am</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 2 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>79</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Lawyer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>self</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Catonville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>n/a</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mabel J. Leitzer 1231 S. Rolling Rd.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ATHEROSCLEROTIC HEART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 HRS</i> <i>YEARS</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this person attended the deceased from <i>JAN 78</i> to <i>PRESENT</i> , 19 <i>78</i> , that (1) <del>lost</del> lost saw the deceased alive on <i>JUNE</i> 19 <i>77</i> , and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (2) we did not view the body after death.					
22b. SIGNATURE <i>Gustav C. Voight M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9 JUNE 79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Gustav C. Voight, M.D.</i>		22e. ADDRESS <i>6 St. Johns Rd.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/12/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Ambrose Funeral Home</i>		ADDRESS <i>1328 Sulphur Spring Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1979</i>	
		25b. REGISTRAR'S SIGNATURE <i>Anthony R. Brady</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 7 0

REG NO

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA J LERENDU			2a DATE OF DEATH MONTH DAY YEAR 6-24-79		2b HOUR 8 A M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Baltimore	13c CITY OR TOWN Oella	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME late Jessie Porter		15 MOTHER'S MAIDEN NAME late Ellen Reaver		13e STREET ADDRESS 785 Oella Ave	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 213 12 2630	17 INFORMANT Leslie S LeR ndu 785 Oella Ave 21043		

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cardiogenic Shock  
410 -  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.  
(b) Anteroseptal myocardial infarction  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (he) (she) (it) attended the deceased from <u>6-21</u> 19 <u>79</u> to <u>6-24</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>Dr. Hsueh HUNG</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>DO-HSUEH HUNG</u>		22e ADDRESS	

23a BURIAL, CREMATION, REMOVAL Burial	23b DATE June 27 '79	23c NAME OF CEMETERY OR CREMATORY Meadowridge	23d LOCATION CITY OR TOWN COUNTY STATE Howard, Maryland
24 FUNERAL DIRECTOR HARRY H WITZKE		25a DATE REC'D. BY REGISTRAR JUN 28 1979	25b REGISTRAR'S SIGNATURE <u>Henry McCready</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 7 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>LAWRENCE</u> MIDDLE <u>S.</u> LAST <u>LESSER</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>6</u> <u>20</u> <u>1979</u>		2b. HOUR <u>9:45</u> AM
3. SEX <u>Male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>2</u> <u>1</u> <u>1907</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.Y.C. N.Y.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Good Samaritan Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Lawyer (Ret)</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Legal</u>
13a. STATE <u>Washington</u>	13b. COUNTY <u>D.C.</u>	13c. CITY OR TOWN <u>D.C.</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>2220 Wyoming Ave N.W.</u>
14. FATHER'S NAME FIRST <u>Jacob J.</u> MIDDLE <u>Lesser</u> LAST <u>RAE</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Goldstein</u>		16. ADDRESS <u>Goldstein</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>	16b. SOCIAL SECURITY NO. <u>578-46-4330</u>	17. INFORMANT <u>FRANCES H. Lesser - SAME as ITEM #13</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Respiratory & Cardiac failure  
3352  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  
(b) Amiotropic lateral Sclerosis  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19/79</u> 19 <u>79</u> to <u>6/20</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/20</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>H. S. Sonwara M.D.</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>6/20/79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. S. Sonwara M.D.</u>	22e. ADDRESS <u>Good Samaritan Hospital</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>6/21/79</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash., D. C.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 25 1979</u>	25b. REGISTRAR'S SIGNATURE <u>Robert M. Bailey</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

1701 1701

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR		REG. NO.		7 9 1 4 3 7 2					
1. DECEASED NAME (TYPE OR PRINT) <b>AGNES LEWATOWSKI</b>				20. DATE OF DEATH MONTH DAY YEAR <b>JUNE 23, 1979</b>		21. HOUR P <b>3:35 M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SIEKIERSKI</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		13e. STREET ADDRESS <b>4307 KOLB AVE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>JOS. LEWATOWSKI 1905 GOUCH ST.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myeloid Leukemia</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one month</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Ischemic Cardiomyopathy</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> 19 <b>79</b> , to <b>6/23</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence S. Friedman, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE S. FRIEDMAN</b>				22e. ADDRESS <b>Johns Hopkins Hosp.</b>					
23a. BURIAL CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>6/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>			
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>				ADDRESS <b>2525 FLEET ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony K. Brady</b>	

BP

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DATE: 1941 JUL 22

RECEIVED

MAIL

WASHINGTON CITY

THE JOHNS HOPKINS HOSPITAL

1941 JUL 22



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 7 3

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BRONZIE WILLIAM LEWIS			2a DATE OF DEATH MONTH DAY YEAR June 19 1979		2b HOUR 6:35 p.m.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 12 28 05		
6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEAT CUTTER		
12b KIND OF BUSINESS OR INDUSTRY SWIFT & CO.		13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY A.A.		
13c CITY OR TOWN PASADENA		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 13 MARGARET AVENUE, 21122		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM MATTHEW LEWIS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES ROSA WOODLAND		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b SOCIAL SECURITY NO. 215-07-0492		17 INFORMANT MARY C. GRANT, 13 MARGARET AVENUE		18 ADDRESS PASADENA, MD.		
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory failure. 5509 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION 6/11, 6/15		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ringing hernia, Exp. 14		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from 6/10, 1979 to 6/19, 1979, that (I) (we) last saw the deceased alive on 6/19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE DEGREE Dr. Palchaudhuri		
22c DATE SIGNED 6/19/79		22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Palchaudhuri		22e ADDRESS 21229		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 06-22-79		23c NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		
23d LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MD.		24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.		25a DATE REC'D. BY REGISTRAR JUN 21 1979		
25b REGISTRAR'S SIGNATURE R. J. Kelly						

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12



THE CITY

AT A SPECIAL

MEETING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, portions should be detached for use as the burial-transit permit. Then please remove to the funeral home, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John L. H. Lewis, Jr.			2a. DATE OF DEATH MONTH DAY YEAR June 17, 1979			2b. HOUR 11:05p	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 12 32		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 912 E. Biddle St.	
14. FATHER'S NAME FIRST MIDDLE LAST John Lewis, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Green						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-24-1903		17. INFORMANT ADDRESS Myrtle Lewis Gillard 912 E. Biddle St.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of head &amp; neck</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes years	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (this hospital) attended the deceased from 19 79 to 17 June 19 79, that (I) (we) last saw the deceased alive on 17 June 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE B. K. Nelson		DEGREE		22c. DATE SIGNED 18 June 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN K Nelson		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/22/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
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24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARVIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 29 79</b>			2b. HOUR <b>10:25A</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 14 16</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>62</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>1</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO.MD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled Veteran</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>Q.A. Co.</b>		13c. CITY OR TOWN <b>Chester</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Wilber B. Lewis</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Mollie Pratt</b>		13e. STREET ADDRESS <b>RD.1 BOX 236 FIRST STREET</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 214-28-7905</b>		17 INFORMANT ADDRESS <b>Mildred Honney, Rt#1 Box#81 Chester, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> 5570 DUE TO, OR AS A CONSEQUENCE OF (b) <b>RETRO-INTRA-ABDOMINAL OR PERITONEAL BLEEDING</b> 2 wks DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROBABLE EMBOLI TO BOWEL</b> unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPOALBUMINEMIA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 21, 19 79</b> to <b>JUNE 29, 19 79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JUNE 29, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Barbara A. Fretwell MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARBARA A. FRETWELL MD</b>				22e. ADDRESS <b>3900 LOCH RAVEN BLVD. BALTO.MD. 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-2-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stevensville Q.A. Co. Md.</b>			
24 FUNERAL DIRECTOR Name <b>Helfenbein-Hubbard Funeral Home</b>				ADDRESS <b>Chester, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1979</b>		25b. SIGNATURE <b>[Signature]</b>	

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 7 6

REG NO

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Paul D. Lewis			2a DATE OF DEATH MONTH DAY YEAR June 6, 1979			2b HOUR 1:40 a.m.	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10 31 14		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ST AGNES HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b KIND OF BUSINESS OR INDUSTRY Unknown	

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md.				13c COUNTY Baltimore		13d CITY OR TOWN Lansdowne		13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f STREET ADDRESS 2341 Monumental Avenue 21227					
14 FATHER'S NAME FIRST MIDDLE LAST Herbert Lewis				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Millard				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b SOCIAL SECURITY NO. 212-01-6485		17 INFORMANT Mrs. Georgette C. Lewis, 2341 Monumental Ave.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiogenic Shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Status post resuscitation &amp; Anoxic Brain Damage</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>5-30-79</u> 19 to <u>6-9-79</u> 19, that (I) (we) lost saw the deceased alive on <u>6-9-79</u> 19 <u>4:40 A.M.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Prasad S. Vankineni M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 6/9/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>PRASAD S. VANKINENI</u>				22e ADDRESS <u>900 CATON AVE</u>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/12/79		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inv. 4107 Wilkens Ave.				25a DATE REC'D. BY REGISTRAR JUN 10 1979		25b REGISTRAR'S SIGNATURE <u>Fitzroy Melroby</u>	

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 7 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lula Ruth LEZON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 27 1979</b>		2b. HOUR <b>8:15 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 28 1918</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1602 Park Avenue</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plastic Co.</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Luffman</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clementine Childress</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212 -46-3323</b>		17. INFORMANT (Husband) ADDRESS <b>Mr. John P. Lezon - 1602 Park Av., City</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with transient ischemic attack and infarction</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>26 June 1979</b> to <b>28 June 1979</b> , that (I) (we) last saw the deceased alive on <b>26 June 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Lauriston L. Keown</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>28 June 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lauriston L. Keown, M.D.</b>		22e. ADDRESS <b>431 E. Lake Av., Balto., Md. 21212</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 30, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av., Balto. 1</b>				
25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick Keedy</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 7 8

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR
JACK W. LIEBERMAN					6 28 1979							11 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE M	WHITE	MONTH DAY YEAR 6 22 1912			67 YRS.			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON, DC	USA				BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE	SINAI HOSPITAL			MANAGER			RETAIL					
13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
MD.	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS								
BALTO.	BALTO.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	APT. F #21208 17 Tentwill Lane -								
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST SAMUEL LIEBERMAN				FIRST MIDDLE LAST PAULINE EHRlich								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT						
YES WWII-ARMY				215-05-8195		17 TENTMILL APTS. #21208 Blanche Lieberman - Saine						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cardiogenic Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial Infarction</u> (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>79</u> , to <u>6/28</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/28</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>R. Reider</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6-28-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RUBEN REIDER</u>				22e. ADDRESS <u>Belvedere at Green Spring Ave. 21208</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b. DATE <u>6/29/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>AITZ CHAIM</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE MARYLAND</u>				
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u> <u>6010 REISTERSTOWN RD. BALTO., MD</u>						25a. DATE REC'D. BY REGISTRAR <u>21215 JUL 3 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Barney McBrady</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 3 7 9

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary J. Ligon			2a. DATE OF DEATH MONTH DAY YEAR 6 5 79		2b. HOUR M M
3 SEX Female	4 RACE Balck	5 DATE OF BIRTH MONTH DAY YEAR 9 16 40		6 AGE (IN YEARS LAST BIRTHDAY) 38 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD	
10 CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Herman R. Ligon			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary I. Wiggins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-34-3438		17. INFORMANT ADDRESS Mary I. Ligon 1706 Druid Hill Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO, OR AS A CONSEQUENCE OF, terminal Cancer of the cervix (c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Thompson DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. PREMPREE, MD, Ph.D				22e. ADDRESS Balto MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/9/79		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.		25a. DATE REC'D. BY REGISTRAR JUN 8 1979			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H 1101 E. North Ave.				25b. REGISTRAR'S SIGNATURE Porter	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 8 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PEAKER M. LILLIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 20 79</b>		2b. HOUR <b>7:30 AM</b>	
3 SEX <b>Female</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/13/ 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>City</b> 13c. CITY OR TOWN <b>Balto.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>936 Poplar Grove St.</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elliott Peaker</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Winnie Peaker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>212-32-1754</b>		17 INFORMANT ADDRESS <b>James Fizer 936 Poplar Grove St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>6/16</b> , 19 <b>79</b> to <b>6/20</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>M. J. Salyer</b>				22c. DATE SIGNED <b>6/20/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SH AFI</b>				22e. ADDRESS <b>2600 Liberty Hts</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. City Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles A. Rice 1300 Eutaw Pl.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. H. H. H.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 8 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADAM DOUGLAS LINDSTROM			2a. DATE OF DEATH MONTH DAY YEAR 6-5-79		2b. HOUR 3:05 PM	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 4, 1979		6 AGE (IN YEARS LAST BIRTHDAY) YRS 1 MONTHS 1 DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) =====		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto. Co.		13c. CITY OR TOWN Randallstown	
14 FATHER'S NAME FIRST MIDDLE LAST Brian D. Lindstrom			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine H. Zamostny			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) =====		17 INFORMANT ADDRESS Brian Lindstrom same as 13 e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Pulmonary Atherosclerosis 7531 DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Polycystic Kidneys. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE V. S. SUMMERS		DEGREE MD		22c. DATE SIGNED 6-6-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. SUMMERS		22e. ADDRESS 14 Ames.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		
23d. LOCATION CITY OR TOWN Brooklyn Pk.		COUNTY A.A. Co.		STATE Md.		
24 FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS 4001 Ritchie Hg., Baltimore		25a. DATE REC'D. BY REGISTRAR JUN 7 1979		
		25b. REGISTRAR'S SIGNATURE Anthony A. Brady				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 3 8 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
GEORGE LOUIS LINGO		June 21 1979		6:15 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
male	white	MONTH DAY YEAR	77 YRS	MONTHS DAYS HOURS MIN.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
male	white	3-17-02	77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Delaware	USA		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	South Balto. Gen Hospital	Engineer	B&O RR		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENT BEFORE ADMISSION)	13b. COUNTY	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
Md.	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1 Eastern Bk 21220		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	161-07-4411			
LOUIS LINGO	LILIAN K. NEARN	ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	161-07-4411	Dorothy T. Williams, 308 Spalding Rd., Wil. Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT					
410- DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) ARTERIOSCLEROSIS					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
DIFFUSE INTESTINAL ISCHEMIA WITH MUCOSAL HEMORRHAGE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 5-24-1979, to 6-21-1979, that (we) last saw the deceased alive on 6-21-1979, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
V. L. ARABSHNA		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6-21-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
V. L. ARABSHNA		South Balto. Gen. Hospital			
23a. BURIAL, CREMATION, REMOVAL (CHECK)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. DATE REC'D. BY REGISTRAR	
Burial	June 23, 1979	Asbury Cemetery	Pont Deposit, Cecil Md.	JUN 26 1979	
23f. FUNERAL DIRECTOR		23g. REGISTRAR'S SIGNATURE		23h. REGISTRAR'S SIGNATURE	
Lee A. Patterson & Son, Perryville, Md. 21903		Dorothy T. Williams		Dorothy T. Williams	

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George Davis  
White  
1870

George Davis  
White  
1870

George Davis  
White  
1870

George Davis  
White  
1870

George Davis  
White  
1870

George Davis  
White  
1870



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 8 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) William Lipsitz			2a DATE OF DEATH MONTH DAY YEAR 6-22-79			2b HOUR 5:30 P.M.			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 7-22-99		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale Geriatric Center & Hosp				12a USUAL OCCUPATION (TYPE OF WORK OR BUSINESS WORKING LIFE) PRESSER XXXXXXXXXX		12b KIND OF BUSINESS OR INDUSTRY MARCUS CORP.	
13a. STATE Maryland		13b COUNTY BALTI		13c CITY OR TOWN city		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS #21215 2915 Edgewood Circle S.	
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL LIPSITZ				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER PLIT					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-03-1000		17 INFORMANT ADDRESS NAT LIPSETTS 3003 NORTHBROOK RD. #21209					
18 CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure 4392 DUE TO, OR AS A CONSEQUENCE OF b): ARTERIO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF c): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Year									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/20/79 19 to 6/22/79 19, that (we) last saw the deceased alive on 6/22/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph J. Berman					DEGREE MD		22c. DATE SIGNED 6/22/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH J. BERMAN					22e. ADDRESS Sinai Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-24-79		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 EESTERSTOWN RD., BALTO., MD 21215					25a. DATE REC'D BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy		

MEDICAL CERTIFICATION

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 8 4

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Emmett T. Loane			2a. DATE OF DEATH MONTH DAY YEAR June 19, 1979			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		8b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 W. Mt. Vernon Place				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing - Telephone Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 746 Camberly Circle	
14. FATHER'S NAME FIRST MIDDLE LAST William Emmett Loane			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella G. Taylor			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 212-03-6344			17. INFORMANT Kathryn H. Loane			ADDRESS 746 Camberly Circle			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>RHEUMATIC H-D. WITH MITRAL REGURGITATION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>6/24</u> 19 <u>73</u> , to <u>6/19</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.									
22b. SIGNATURE Donald L. Somerville				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald Sommerville				22e. ADDRESS 26 W. Pennsylvania Ave.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 6/22/79		23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE History McCreedy	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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DOI: 10.1111/j.1365-3113.2011.04511.x

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 8 5

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTELLE M. Logue		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR June 18, 79 7:00 AM	
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 12 08	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	6 AGE (IN YEARS LAST BIRTHDAY) 70 YEARS	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TICKET SALES		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. STATE Md		13b. COUNTY CARROLL	13c. CITY OR TOWN Westminster
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sillian Thomas	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 219-12-1595	17 INFORMANT ADDRESS Paul A. Logue Westminster, Md
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 5050 DUE TO, OR AS A CONSEQUENCE OF (b) leukemia, acute myelocytic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-23, 1979, to 6-18, 1979, that (I) (we) lost saw the deceased alive on 6-18, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE John Minkowski	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 6/18/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JHN MINKOWSKI		22e. ADDRESS UNIVERSITY HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-21-79	23c. NAME OF CEMETERY OR CREMATORY COTTEWAGE CHAPEL	23d. LOCATION CITY OR TOWN COUNTY STATE RD NADDER ADAMS PA
24 FUNERAL DIRECTOR NAME Robert Kyle Puth Sr		25. DATE RECEIVED BY REGISTRAR JUN 25 1979	

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10-2



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 3 8 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST W.	MIDDLE CARL	LAST LOHMEYER	2a. DATE OF DEATH MONTH DAY YEAR 6 16 79		2b. HOUR 9 39 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 23 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6318 Mossway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ch. of Bd.		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6318 Mossway				
14. FATHER'S NAME FIRST MIDDLE LAST Carl Lohmeyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madge Celeste White						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 216 05 8490		17. INFORMANT ADDRESS Mrs. W. Carl Lohmeyer 6318 Mossway				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 10 YEARS								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Occasionally as substitute for Dr. Louis Hamburger				
22a. I certify that (I) <del>this hospital</del> attended the deceased from 19 <u>69</u> to <u>June 16</u> 19 <u>79</u> , that (I) <del>was</del> last saw the deceased alive on 19 <u>78</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>did not</del> view the body after death.								
22b. SIGNATURE Robert W. Garis, M.D. (for Dr. Louis Hamburger who was at Ocean City past week. He had phoned me a week ago.)				DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-17-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Garis				22e. ADDRESS 12 E. Eager St. Balto. Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-17-79		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Henry W Jenkins & Sons 4905 York Rd.				25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0804121







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 14387

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virgin Agnes Long		2a. DATE OF DEATH MONTH DAY YEAR 6 3 '79		2b. HOUR 2 <sup>03</sup> P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 2 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Md.		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Sadler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 217-26-4491		17. INFORMANT ADDRESS Balto., Md. 21225 Mr. Edward J. Long 215 Franklin Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organizing pneumonia &amp; lung edema</u> <u>5672</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>focal peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>nephrosclerosis bilateral disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Generalized arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 6-1-'79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abscess with Sigmoid Perforation		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> 19 <u>79</u> , to <u>6-3</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kazuaki Okubo		DEGREE		22c. DATE SIGNED 6-3-'79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kazuaki Okubo		22e. ADDRESS 3001 S. Hanover St. Md. 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 7, 1979	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Anne Arundel Md.
24. FUNERAL DIRECTOR NAME Mc Call Funeral Home of Brooklyn 237 E. Patapasc Avenue		25a. DATE REC'D. BY REGISTRAR 21225 JUN 5 1979		25b. REGISTRAR'S SIGNATURE L. J. McCall	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

1889



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14388

1. DECEASED NAME (TYPE OR PRINT)		FIRST HARRY	MIDDLE C.	LAST LOWENSTEIN	2a. DATE OF DEATH MONTH DAY YEAR JUNE 29, 1979	2b. HOUR J: 30. A. M.
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH JUNE 25, 1899 <sup>AR</sup>		6 AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3409 PINWOOD AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN		12b. KIND OF BUSINESS OR INDUSTRY SHIPS	
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3409 PINWOOD AVE. #21206	
14 FATHER'S NAME FIRST MIDDLE LAST DAVID LOWENSTEIN		15 MOTHER'S MAIDEN NAME FIRST LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWI-ARMY 218-09-7646		17 INFORMANT MRS. FLORENCE KRUBA 3409 PINWOOD AVE. #21206		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA, URINARY BLADDER 1899 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ASCVD, DIABETES MELLITUS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1974, to APRIL 4, 1979, that (I) (we) lost saw the deceased alive on APRIL 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Fausto Q. Aquino		DECEASEE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-29-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. FAUSTO AQUINO		22e. ADDRESS 8713 HARFORD RD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 1, 1979		23c. NAME OF CEMETERY OR CREMATORY HEBREW ORTHO. MEM. SOC.		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained with 24 hours after the death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VRA 15 (4))

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ardella Lillian Lowry</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 22, 1979</b>		2b. HOUR <b>01:22 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 14 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assembler</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Pasadena</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1198 Sillery Bay Rd. North Shore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Henry Lowry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Rebecca Evans</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-07-4336</b>		17. INFORMANT ADDRESS <b>Clarence Bouis Same as 13 Brother-in-law</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto Accident</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auto accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>CH 79 622 79</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>6/21</b> 19 <b>79</b> , to <b>6/22</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/21</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>		DEGREE		22c. DATE SIGNED <b>6/22/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>		22e. ADDRESS <b>CH 79</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/26/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Mc Cully F.H. Mountain &amp; Tick Neck Rds. Pas. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 3 9 0	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM Thomas LUCAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-5-79</b>							2b. HOUR <b>8:50 AM</b>	
3 SEX <b>MALE</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 21, 1907</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2671 Hafer Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Herbert Lucas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Mabel Childs</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-18-5915</b>			
17. INFORMANT <b>Mrs. Lillian B. Smith</b>		ADDRESS <b>Rt. 1 Box 214</b>			18. DELMAR, DEL. 19940						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Sleep Disorder</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>May 25</b> 19 <b>79</b> , to <b>June 5</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Araya Chansanchai</b>				DEGREE <b>H.O.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARAYA CHANSANCHAI</b>				22e. ADDRESS <b>Lutheran Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MacNabb Funeral Home Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Histroy McBrady</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14391

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR											
Dennis						Lyles		XX		6		17		1979		M											
SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR							
Male		Black		DEC 7, 1978		6 YRS.		6 MONTHS		10 DAYS		6		17		1979		9:43P		M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH															
MARYLAND		USA										Baltimore City, MD.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																					
Baltimore City		Union Memorial Hospital		UNEMPLOYED																							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																			
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		402 WHITRIDGE AVENUE																			
14. FATHER'S NAME				MIDDLE				LAST				15. MOTHER'S MAIDEN NAME				MIDDLE				LAST							
KENNETH								DIGGS				VALERIE								LYLES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS															
NO				NONE				VALERIE LYLES				402 WHITRIDGE AVENUE															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome																											
7980																											
DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																											
(b)																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?											
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
				HOUR A.M. MONTH DAY YEAR																							
				P.M. 19																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
TITLE (SPECIFY)																											
ACTUAL SIGNATURE Virginia L. Dolan M.D. Assistant																		DATE SIGNED 6/18/79									
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.																		ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				CITY OR TOWN				COUNTY				STATE			
CREMATION				6/19/79				WESTVIEW MEMORIAL PARK				BALTIMORE (BALTO.)				MD.											
24. FUNERAL DIRECTOR																		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
X L. LEWIS T. GWYNN 4517 PARK HEIGHTS AVE.																		JUN 19 1979		L. J. McCreedy							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 4. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14392

1. STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
THOMAS HENRY LYLES		6 29 19 79		1:15 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	Black	4 6 01	78 YRS		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
MD.	Baltimore	1701 Linden Avenue	Ret.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD.		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1701 Linden Ave.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	17. ADDRESS
Rubin H. Lyles	Margaret T. Green	No	218-10-4045	Mrs. Ada Lyles	1701 Linden Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED			
Virginia L. Dolan	Assistant	6/29/79			
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS				
Virginia L. Dolan, M.D.	111 Penn Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	7-3-79	King Memorial Park	Baltimore		MD.
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Samuel T. Redd 5209 York Rd. Balto. Md	JUL 10 1979				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Queen E. Lynch			2a. DATE OF DEATH MONTH DAY YEAR 6 3 79		2b. HOUR M
3 SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 11 21		6 AGE (IN YEARS (LAST BIRTHDAY)) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3623 Garrison Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3623 Garrison Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Fleet			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Kenneth Lynch	
				ADDRESS 7101 Rudisill Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cad. Respiratory Arrest</u> <u>4/49</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cordice arrhythmic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic heart disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Rheumatoid arthritis</u> <u>CHF</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October</u> 19 <u>78</u> to <u>May 3</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>May 1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>RD Jackson</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>6/4/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rebecca D. Jackson MD</u>		22e. ADDRESS <u>Johns Hopkins Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>6/8/79</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arbutus, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H</u>		ADDRESS <u>1101 E. North Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 5 1979</u>	
				25b. REGISTRAR'S SIGNATURE <u>Henry K. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 3 9 4

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN MABRY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 30 79</b> 2b. HOUR <b>6:30 p.m.</b>		
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 30 89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC BALTIMORE, MARYLAND 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>12b. KIND OF BUSINESS OR INDUSTRY</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT MABRY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI 217 01 0766</b>		17. INFORMANT ADDRESS <b>Beulah Mabry, 1605 Hakesley Pl.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown</b> <b>79999</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Organic Brain Syndrome</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 29</b> , 19 <b>79</b> , to <b>JUNE 30</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above <b>30</b> (we) (did not) view the body after death.					
22b. SIGNATURE <b>Kristen Raines</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/30/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kristen Raines</b>		22e. ADDRESS <b>VAMC BALTIMORE MD 7 Overhill Rd Catonsville MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Charleston, W. Va.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		23f. REGISTRAR'S SIGNATURE <b>Ruthy McBrady</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		24b. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 9 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mark H. MACKLIN			2a. DATE OF DEATH MONTH DAY YEAR June 18, 1979			2b. HOUR 4:10 P		
3. SEX Female	4. RACE Col	5. DATE OF BIRTH MONTH DAY YEAR 10 11 05		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN
9. BIRTHPLACE (STATE OR FOREIGN) Phila. Pa	10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker Beth Steel
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Haskins Marklin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Euba Mayers		16. ADDRESS 2314			17. STREET ADDRESS 2314 Asgwith St
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			18b. SOCIAL SECURITY NO. 299-03-5058		19. INFORMANT Virginia Macklin			20. ADDRESS 2314 Asgwith St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 0703 DUE TO, OR AS A CONSEQUENCE OF (b) Hepatitis B Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Gastric Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 3, 1979, to June 18, 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 18, 1979, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.								
22b. SIGNATURE T. Macpherson						DEGREE M.D.		22c. DATE SIGNED 6/18/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Macpherson, M.D.						22e. ADDRESS c/o Maryland General Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/23/79		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md	
24. FUNERAL DIRECTOR NAME Powell F H 319 N. Schroeder St						25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE R. J. H. Hardy

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 3 9 6

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK E. MADDEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 30 1979</b>			2b. HOUR <b>07:30AM</b>				
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>2 9 91</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>07 30 00</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>				
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1002 Wilmot Ct.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Madden</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Iler</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>214-56-9937</b>			17. INFORMANT <b>Viola Goldring</b>			ADDRESS <b>5037 Queensberry Ave</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>79</b> , to <b>6/30</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/30</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>K. March</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/30</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. March</b>						22e. ADDRESS <b>Johns Hopkins</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevenson A.M.E. Ch.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sparks, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>						ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		
						25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, who should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH, IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14397

1- STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
John T Madden		X MONTH DAY YEAR 6 17 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
male	white	Aug. 2, 1908	70 RS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Massachusetts		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Baltimore		University Hospital STU	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Retired		Press Club	
13a. STATE		13b. CITY OR TOWN	
Maryland		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Luke F. Madden		Mary A. Buckley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
yes		WW 11 577-05-3079	
17. INFORMANT		ADDRESS	
John A. Botts, Jr. - Exec-Chillum, Md.		5415 15th Pl	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Complication of visceral and skeletal injuries</u>			
(b) <u>Due to, or as a consequence of</u>			
(c) <u>Due to, or as a consequence of</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY	
XX driver of auto/auto collision		? 5/18 1979 P.M.	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		street	
21f. LOCATION		21g. LOCATION	
Rt 216 & Rt 108,		CITY OR TOWN	
		Howard Co, MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Virginia L. Dolan		Assistant	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Virginia L. Dolan, M.D.		6/17/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		6-21-1979	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Gate of Heaven		Sil. Spr. Montgomery Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Wayner E. Pumphrey, Inc.		JUN 2 1979	
8434 Ga. Ave., S.S. Md.		25b. REGISTRAR'S SIGNATURE	
		Henry McCreedy	



Items #18a-22a Film G534 8/2/79 reSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 4 3 9 8  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Donald E. Magri</b>		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>6 9 19 79</b>		2b. HOUR M <input type="checkbox"/> A <input type="checkbox"/> <b>5:01</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>Feb. 26, 1952</b>	6. AGE (IN YEARS) LAST BIRTHDAY: MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> <b>27 YRS.</b>	7c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>6 9 19 79</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Repairman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Md. Business School</b>
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Balto.</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>5404 Rimmell Ave. -21206</b>
14. FATHER'S NAME FIRST <b>Samuel J. Magri</b> LAST <b>Magri</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mildred M. Paesch</b> LAST <b>Paesch</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-60-1417</b>		17. INFORMANT <b>Mr. Samuel J. Magri -5404 Rimmell Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>3049 Acute narcotism</b> IMMEDIATE CAUSE (a) <b>Acute narcotism</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>6/9/79</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6-12-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd. -21206</b>		25. DATE RECEIVED BY REGISTRAR <b>JUN 11 1979</b>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

8 9 9 8



Feb. 2, 1952

Received of Mr. J. H. [illegible]  
the sum of \$100.00

For [illegible]

[illegible]

[illegible]

Very truly yours,  
[illegible]

[illegible]

[illegible]

Very truly yours,  
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 1 4 3 9 9

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT)			3 SEX			4 RACE			
JOHN E. MAGUIRE			Male			White			
5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			
MONTH DAY YEAR			YRS MONTHS DAYS			Maryland			
Mar. 4 1900			79			U.S.A.			
8 MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH			
			BALTIMORE CITY MD.			BALTIMORE			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
UNION MEMORIAL HOSPITAL			Gen. Contractor						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS			
13a STATE 13b COUNTY 13c CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Balt., Md. 21214			
Maryland Baltimore						5300 Holder Avenue			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. SOCIAL SECURITY NO.			
Charles E. Maguire			Henrietta McDowell			214-34-4849			
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17 INFORMANT			ADDRESS			
Yes WW I			Wife: Ida V. Maguire			Balt., Md. 21214			
						5300 Holder Avenue			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
5336 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Respiratory Insufficiency</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Asphyxia</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
S/P Resection of Ca-esophagus 1972; Overlying GE marginal ulcer									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/6/79			Bleeding from ulcer			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/6 19 79 to 6/27 19 79, that (I) (we) last saw the deceased alive on 6/27 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Patrick McMenamin MD						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
McMenamin MD						UMM. Balt MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			Jun 30 1979		Parkwood Cemetery		Baltimore Maryland		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS						JUN 29 1979		Patricia K. Bandy	
Leonard J. Ruck, Inc. Baltimore, Maryland									

P P L H I V A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 0 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) GENEVIEVE			FIRST MIDDLE LAST NAINES			2a DATE OF DEATH MONTH DAY YEAR 6/19/79				2b HOUR 2:15 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 19 1912		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7a UNDER 1 YEAR MONTHS DAYS		7b UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b KIND OF BUSINESS OR INDUSTRY Masonic Homes			
13a STATE Md.						13b COUNTY		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Ernest Martin						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Artelia Armstrong					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-12-1503		17 INFORMANT ADDRESS Joanne Gardner (dghtr) same address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 6/12 19 79, to 6/19 19 79, that (I) (we) lost saw the deceased alive on 6/14 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE B.K. Yorkoff - MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Yorkoff.						22e ADDRESS Union Memorial Hospital					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 6/19/79		23c NAME OF CEMETERY OR CREMATORY Greenmount Crematory			23d LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24 FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.			ADDRESS 3331 Brehms Lane Balto. Md. 21213		DATE REC'D. BY REGISTRAR 3 JUN 19 1979		25b REGISTRAR'S SIGNATURE [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001A [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14401

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM STREIT MANGOLD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 22, 1979</b>		2b. HOUR <b>2:10 AM</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 14 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTING CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MD BALTIMORE ARBUTUS</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21227 5530 CARVELLE AVENUE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM MANGOLD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA STREIT</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
17. SOCIAL SECURITY NO. <b>705-05-2948</b>		18. INFORMANT ADDRESS <b>MRS. MIRIAM E. ROIGER, 5531 LINK AVENUE 21227</b>					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suicide</b> 2850 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Active Hepatitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sideroblastic Anemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/6/1979</b> to <b>6/22/1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6/22/1979</b> , and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do) not view the body after death.							
22b. SIGNATURE <b>V. Sukumar</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/22</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. SUKUMAR</b>		22e. ADDRESS <b>ST. AGNES HOSPITAL 900 S CATON AV BALTIMORE, MD., 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>BALTO., MD. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

10. 11. 1954

11. 11. 1954

12. 11. 1954



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14402

1- STATE REGISTRAR		FOR	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE KNOWN OF DEATH	
John T. Mann		MATED <input checked="" type="checkbox"/> MONTH DAY YEAR	
3 SEX		2b DATE PRONOUNCED DEAD	
Male		6 30 19 79	
4 RACE		2c DATE KNOWN OF DEATH	
Black		6 30 19 79	
5 DATE OF BIRTH		2d HOUR	
3 17 57		2:58A	
6 AGE (IN YEARS)		2e BALTIMORE CITY OR COUNTY OF DEATH	
22 YRS.		Baltimore City, MD.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md.		USA	
7b CITIZEN OF WHAT COUNTRY?		9 BALTIMORE CITY OR COUNTY OF DEATH	
USA		Baltimore City, MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Baltimore City		243 S. Ballou Court	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE		13b CITY OR TOWN	
Md.		Balto.	
13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS	
		243 Ballou Court	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME	
Sam Mann		Beatrice Evan	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.	
No		219-66-9350	
17 INFORMANT		ADDRESS	
James Mann		442 E. 23rd St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Stab wound to chest			
966 -			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY	
2:58XX 6 30 19 79		stabbed by assailant	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		house	
21f LOCATION		21g CITY OR TOWN	
243 S. Ballou Court			
22a I certify that I look upon the foregoing as the true and correct description of the death of the deceased, and in my opinion death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Thomas D. Smith, M.D.		Deputy Chief	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
		6/30/79	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
Burial		7/5/79	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Mt. Calvary Cem.		Anne Arundel Co., Md.	
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR	
Wm C March F/H		JUL 5 1979	
25b REGISTRAR'S SIGNATURE			

5

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8



1943 Ballon Court

X

1943

1943

1943-1944 James Henry

1943

1943



Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 14403	
1. DECEASED NAME (TYPE OR PRINT) <b>JACK</b>			FIRST MIDDLE LAST <b>MANNES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 20, 1979</b>			2b. HOUR P. <b>11:25 P.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 29, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>			MD		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3900 N. CHARLES ST., APT. 1106</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3900 N. CHARLES ST. #21218</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JONAS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE GOLDSMITH</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>212-26-565</b>		
17. INFORMANT <b>MRS. JUDY BORTNER</b>			17. ADDRESS <b>117 4TH ST. S.E., WASHINGTON, DC</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, pancreas</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-79 -</b> <b>approx. 4 mos.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1977</b> , 19____, to <b>June, 1979</b> , that (I) (we) lost saw the deceased alive on <b>6-16-79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Samuel Whitehouse</i>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6-21-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SAMUEL WHITEHOUSE</b>			22e. ADDRESS <b>3900 N. CHARLES ST.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>				
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert McBrady</i>			

2001-1-1

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**MEDICAL CERTIFICATION**

DHMH - 16 60M 1/75  
(VR A 15 (4))

4 0 8 1 2



JUNE 6 1973

RECEIVED

1973

BIRMINGHAM CITY

W. J. WATSON GENERAL HOSPITAL

BIRMINGHAM

RESPIRATORY ARREST

SEVERE RESPIRATORY DISTRESS, LARGE PLEURAL EFFUSION, HYPOTENSION

LARGE PLEURAL EFFUSION

JUN 21 1973

JUN 6 1973 JUN 6 1973 JUN 6 1973

C/O WATSON GENERAL HOSPITAL

W. J. WATSON, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 0 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Joseph J. MARKOWSKI, SR</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>6 21 79</u>		2b. HOUR <u>4:30A</u>
3. SEX <u>Male</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>July 4, 1914</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>64</u> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Long Shoreman</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>I.L.A. Union</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>			13b. COUNTY <u>-</u>	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Stephen Markowski</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Stella Kicka</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>1941</u>		17. INFORMANT ADDRESS <u>Doris E. Markowski (wife) same as 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> <u>2000</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HISTIOCYTIC LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/21</u> 19 <u>79</u> to <u>6/21</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stephen K. Dyal</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>6/21/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEPHEN K. DYAL</u>		22e. ADDRESS <u>301 ST. PAUL PL. 21202</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>6/25/79</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S NAME <u>Schimmunek Funeral Home, Inc.</u>		24b. ADDRESS <u>2331 Brehms Lane Balto. Md. 21213</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 26 1979</u>	25b. REGISTRAR'S SIGNATURE <u>Forney</u>

BP

2011-1-1

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 0 6

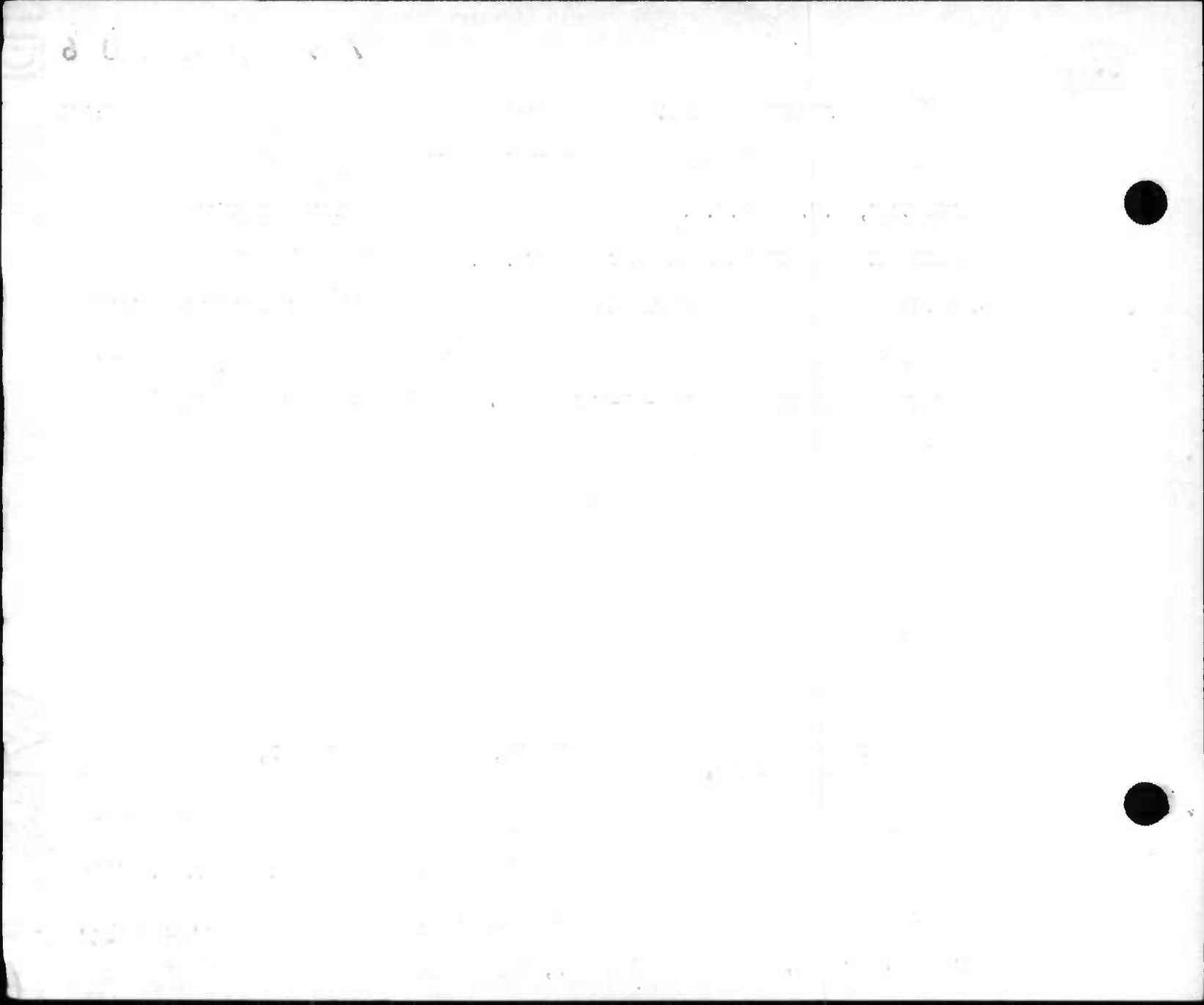
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JEROME EDWARD MARKS			2a DATE OF DEATH MONTH DAY YEAR 6 7 79			2b HOUR 7:35A M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 10/1 / 11		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO.MD.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Binder	
13a STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Raymond Marks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Wade		13e STREET ADDRESS 911 HAMMONDS LANE 21225			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. WW II		17 INFORMANT Mrs. Naomi Marks same as 13 e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic squamous CA 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) lung CA DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Severe peripheral vascular disease							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from APRIL 12, 19 79, to JUNE 7, 19 79, that (X) (we) last saw the deceased alive on JUNE 7, 19 79, and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (our) view the body after death.							
22b SIGNATURE Charles Newton				DEGREE M.D. PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 6/7/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles Newton				22e ADDRESS 3900 LOCH RAVEN BLVD. BALTO.MD. 21218			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/11/1979		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. BALTO.MD.	
24 FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore				25a DATE RECEIVED BY REGISTRAR JUN 7 1979			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 0 7

1. DECEASED NAME (TYPE OR PRINT) ALPHONSE JOSEPH Marotta		2a. DATE OF DEATH MONTH DAY YEAR 6/29/79		2b. HOUR 12 <sup>30</sup> PM	
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 23, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sanitation		12b KIND OF BUSINESS OR INDUSTRY City Baltimore
13a STATE Maryland		13b COUNTY -	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Frank Marotta		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marianna Dinisio			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 DECEASED'S ADDRESS Frank Izzo (nephew) 7802 Bennerton Drive 21206	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> <u>4292</u> DUE TO, OR AS, A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive heart failure</u> DUE TO, OR AS, A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular disease</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes</u> <u>heel ulcer</u>					
19a DATE OF OPERATION <u>June 26, 1979</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Debridement heel ulcer</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>79</u> , to <u>June 29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b SIGNATURE <u>Gregory D McCormack MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <u>6/29/79</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>McCormack</u>		22e ADDRESS <u>Mercy Hospital</u>			
23a BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		23b DATE <u>7/3/79</u>		23c NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	
23d LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>		23e DATE REC'D. BY REGISTRAR 23f REGISTRAR'S SIGNATURE <u>JUL 3 1979</u> <u>[Signature]</u>			
24 FUNERAL HOME NAME <u>McCormack Funeral Home, Inc.</u>		24b ADDRESS <u>3331 Brehms Lane Balto. Md. 21213</u>			

NO. 1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 0 8

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alfred E. Marschall</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6 24 79</b>		2b. HOUR <b>9:52 pm</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 2, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Free Lance Technical Writer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Marschall</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene E. McGloin</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW2</b>		16b. SOCIAL SECURITY NO. <b>217-03-0906</b>	
16c. ADDRESS <b>Mrs. Iva R. Marschall</b>		16d. ADDRESS <b>6029 Alta Avenue</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b> <b>585-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Chronic renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Seizure disorder</b> <b>~1 yr.</b> <b>~3 weeks</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:52 (PM) 6 24 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/5</b> , 19 <b>79</b> , to <b>6/24</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dolores Shoback MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/24/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dolores Shoback</b>				22e. ADDRESS <b>Dept. of Medicine, Johns Hopkins Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-28-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McRandy</b>	

80, 20, 10, 5



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 0 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Jesse C. Marshall</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 9, 1979</b>		2b. HOUR <b>4:00</b> <b>XX XX AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 11 26</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		8. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>1911 Eutaw Pl.</b>		
13b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>James Marshall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Mae Wall</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>245-28-2268</b>		17. INFORMANT ADDRESS <b>Valter Lee 5819 Gist Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>metastatic cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from <b>5/25</b> 19 <b>79</b> , to <b>6/9</b> 19 <b>79</b> , that (b) (we) last saw the deceased alive on <b>6/9</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (do not) view the body after death.						
22b. SIGNATURE <b>Allen Acuff</b>		DEGREE <b>PHYSICIAN</b>		22c. DATE SIGNED <b>6/9/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen Acuff</b>		22e. ADDRESS <b>601 N. Broadway BALTO MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>		

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14410

1. DECEASED NAME (TYPE OR PRINT) <b>Russell R. Marshall</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 19, 1979</b>			2b. HOUR <b>10:10<sup>PM</sup></b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 1 39</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>40</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemploy.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1806 E. Eager St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Marshall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Cornish</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-26-4040</b>		17. INFORMANT <b>Annie D. Marshall</b>		ADDRESS <b>1806 E. Eager St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>4589</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>cirrhosis &amp; gastrointestinal bleed</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/19 7:5 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6/19 79</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/19 79</b> to <b>6/19 79</b> , that (I) (we) lost saw the deceased alive on <b>6/19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kenneth March</b>						DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>6/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth March</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>			

01410

10:10p

June 12, 1970

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Memphis City

The Commercial Appeal

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#15, Filing 532 6/27/79 kam

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14411

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Darryl K. Martin			ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 13 19 79			6:30 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		
Male	White	May 11, 1960	19 YRS.	MONTHS	DAYS	6 13 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Kentucky		U.S.A.				Baltimore City, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City		University Hospital		Surveyor Helper				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS				
Billy Lee Martin		Betty Lou Long		1405 Race St. Balto. Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		214-74-5508		Mr. Billy Lee Martin, Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8122 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:57xx 6 13 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
				driver in motorcycle/auto impact				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 648 & Ferndale, A.A. MD				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		TITLE (SPECIFY)					DATE SIGNED	
Hormez R. Guard		Assistant MEDICAL EXAMINER					6/14/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
Hormez R. Guard, M.D.		111 Penn St. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY, TOWN, COUNTY, STATE		
Burial		June 16, 1979		Cedar Hill Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR (NAME)				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
McCully Funeral Home, 130 E. Font Ave. Balto. Md.				JUN 18 1979		Fitzgerald		

1111111111



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 1 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret H Martin</b>		2a DATE OF DEATH MONTH DAY YEAR <b>6/ 6 23 79</b>		2b HOUR <b>4P</b> M	
3 SEX <b>Female</b>		4 RACE <b>Wht</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 31 01</b>	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		6b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		6c AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		7c BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
8 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		9 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Guter</b>		10 USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BLACK + DECKER</b>	
11 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>		13b COUNTY <b>BALTO</b>		13c CITY OR TOWN <b>Baltimore</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John C. FRANCIS</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARYM IPPIG</b>		16 STREET ADDRESS <b>8302 OAKLEIGH ROAD</b>	
17a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		17b SOCIAL SECURITY NO. <b>612-10-9473A</b>		17c INFORMANT <b>FAMILY RECORDS</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Old Carcinomas and/or accident</b> <b>438-</b> DUE TO, OR AS A CONSEQUENCE OF <b>Old Hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Chronic Bronch Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF <b>Multiple Deformities</b> (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>8/14/1979</b> to <b>6/23/1979</b> , that (I) (we) last saw the deceased alive on <b>6-23-1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>[Signature]</b>		DEGREE		22c DATE SIGNED <b>6/24/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR SAWANEY</b>		22e ADDRESS <b>205 B+A Blvd, Glen Burnie Md 2106</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>6/26/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. COUNTY MD.</b>		23e DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		23f REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>EVANS FUNERAL CHAPEL 8800 HANFORD RD</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 1 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES</b>			FIRST MIDDLE LAST <b>MASON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 2 79</b>			2b. HOUR <b>1115P M</b>				
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 11 16</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>			MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laymentress</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Mason</b>					
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>3804 HILLDALE ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Mason, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carolina Harris</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO <b>225-03-0926</b>			17. INFORMANT ADDRESS <b>Shirley M. Royce 245 14th N E. Wash., D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY <b>5849</b> IMMEDIATE CAUSE (a) <b>Severe Renal Failure with rising BUN</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Also death complicated by CHF and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumonia</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPERTENSION</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 13</b> 19 <b>79</b> to <b>June 2</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Philip Jay Schwartz MD</b>						DEGREE			22c. DATE SIGNED <b>6/2/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PHILIP JAY SCHWARTZ</b>						22e. ADDRESS <b>SINAI HOSPITAL - BALTIMORE MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/7/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 7 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Philip Jay Schwartz</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

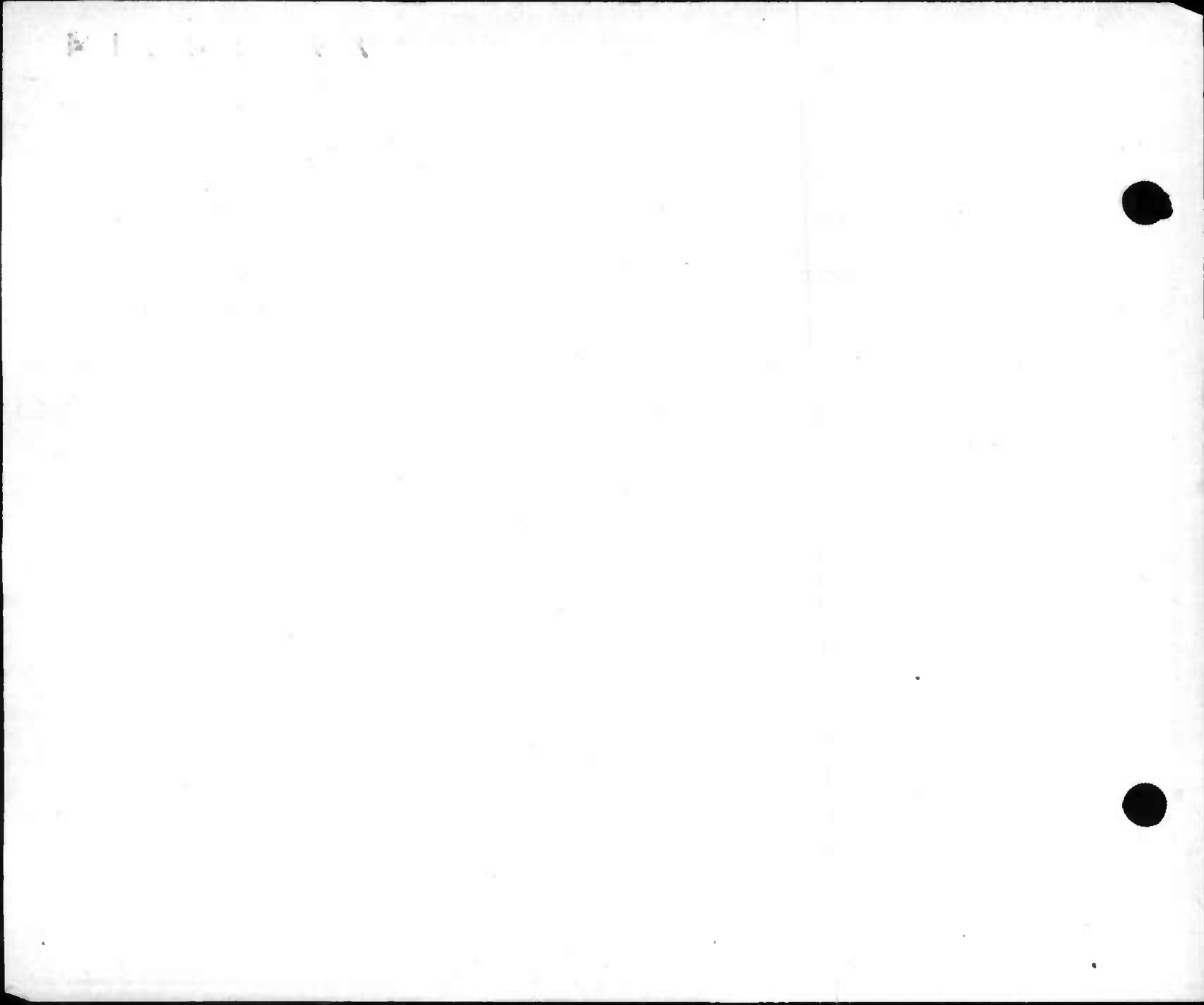
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 1 4

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH MASON			2a DATE OF DEATH MONTH DAY YEAR 6-25-79		2b HOUR 7.35 PM	
3 SEX Male	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 8 7 1904		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	9 CITIZEN OF WHAT COUNTRY? USA	10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
12 CITY OR TOWN OF DEATH BALTO.	13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN Hosp.			14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15 KIND OF BUSINESS OR INDUSTRY
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Mason		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cousins Lewis		16 STREET ADDRESS 107 N. Schroeder St.		
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		18 SOCIAL SECURITY NO. 217-09-6571		19 INFORMANT Mrs. Lena Reese 1121 Wheeler Ave		
20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days yrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22 I certify that (1) this hospital attended the deceased from 6-2-79 to 6-25-79, that (1) (we) lost the deceased alive on 6-25-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.						
22a SIGNATURE Hassan Khan		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 6-25-79
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL SAMAN KHAN		22e ADDRESS LUTHERAN HOSPITAL OF MD. BALTO.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 6/29/79	23c NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24 FUNERAL DIRECTOR NAME Parrell Funeral Home		ADDRESS 39 N. Schroeder		25a DATE REC'D. BY REGISTRAR JUN 29 1979		25b REGISTRAR'S SIGNATURE Hassan Khan







2008 年 5 月 10 日

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 14416				
1. FOR STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
BABY BOY					MATHIS		"B		6-		1	79	7:40A <sup>M</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		White		MONTH DAY YEAR 5 24 79		0 YRS 0 YRS		MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
BALTO		U.S.				Baltimore City MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE		MERCY HOSPITAL		infant										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md				Balt		YES <input type="checkbox"/> NO <input type="checkbox"/>								
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST		FIRST MIDDLE LAST												
Carl Lee		MATHIS Smith												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		-		Jacqueline Fulton MD		301 St Paul Place								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a)										cardiac arrest				
769- DUE TO, OR AS A CONSEQUENCE OF										1 1/2 hrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) severe hyaline membrane														
DUE TO, OR AS A CONSEQUENCE OF														
(c) disease, pneumothorax, prematurity														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
5/31/79		Pneumomediastinum		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)										
		P.M. 19												
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET										
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 19 79, to 6/1, 19 79, that (I) (we) lost saw the deceased alive on 6/1, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		DEGREE		22c. DATE SIGNED										
Jacqueline C. Fulton MD		MD		6/1/79										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
JACQUELINE FULTON		301 St Paul Place (Pediatric Dept)												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Removal		6/7/79												
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Anatomy Board		Balto., Md.		JUN 12 1979		Patricia M. Brady								

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 1 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HERBERT E. MATTHEWS			2a. DATE OF DEATH MONTH DAY YEAR 6/7/79			2b. HOUR 8:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-24-1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 -		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Painter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2938 Independence Street -21218			
14. FATHER'S NAME FIRST MIDDLE LAST Vernon Matthews			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Holtzman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 00011		17. INFORMANT ADDRESS Mrs. Louise J. Matthews - 2938 Independence St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>SEVERE COPD, SEPSIS?</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION 6/4/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCENDING CHOLANGITIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/7</u> 19 <u>79</u> , to <u>6/7</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/7</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Servando Sanchez</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/7/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SERVANDO SANCHEZ M.D.				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-11-79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland-			
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE RECEIVED BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE <u>John C. Miller</u>			

AL. B. I. R. A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE L. MAY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 4, 1979</b>			2b. HOUR MIN. <b>1.25 AM</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 19, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) <b>4111 Hamilton Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed Air Conditioning</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4111 Hamilton Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Chandler May</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evora Lombard</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>182-01-4210</b>		17. INFORMANT ADDRESS <b>Mrs. Wilhelmina May 4111 Hamilton Ave.</b>					
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b> <b>4092</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 17, 1960</b> to <b>May 1 June 3, 1979</b> that (I) (we) last saw the deceased alive on <b>May 18, 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. G. William Benedict</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4 June 79.</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. G. William Benedict</b>					22e. ADDRESS <b>2 W. University Parkway, Balto, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 6, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>					ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>	

June 4, 1919

July 12, 1919

August 12, 1919

Self-Insured Air Transportation

Self-Insured Air Transportation

Self-Insured Air Transportation

Self-Insured Air Transportation

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 1 9

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>Matthias W. Mayer</b>		2a DATE OF DEATH MONTH DAY YEAR <b>June 23 79</b>		2b HOUR <b>8:40 AM</b>	
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Oct. 24, 1926</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Crown, Cork Seal</b>
13a STATE <b>Maryland</b>		13b COUNTY <b>-</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Matthias Mayer</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Vacek</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-20-0273</b>		17 INFORMANT ADDRESS <b>Diana Mayer (wife) 4706 Moravia Road 21206</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4275 Cardio Pulmonary arrest</b> IMMEDIATE CAUSE (a) <b>Cardio Pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 27 19 79</b> to <b>June 25 19 79</b> , that (I) (we) lost saw the deceased alive on <b>June 23 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Waldredo J. Leon</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Waldredo J. Leon</b>		22e. ADDRESS <b>Baltimore City Hospital</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>6/26/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem. Baltimore, Md.</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		23e DATE REC'D BY REGISTRAR <b>JUN 26 1979</b>		23f REGISTRAR'S SIGNATURE <b>R. J. Kelly</b>	
24 FUNERAL HOME NAME <b>Scerifunek Funeral Home, Inc.</b>		24b ADDRESS <b>3331 Brehms Lane Balto. Md. 21213</b>			

BP

911-41-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14420

1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 17, 1979</b>			2b. HOUR <b>05:40pm</b>		
3. SEX <b>MALE</b>			4. RACE <b>BLACK</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>8 18 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HERBERT FISHER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE MAYFIELD</b>			12b. KIND OF BUSINESS OR INDUSTRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>7689</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <b>PROFOUND HYPOXIA</b> c) <b>PULMONARY HYPERTENSION</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 MIN</b> <b>35 HRS</b> <b>35 HRS</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>-</b> <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>-</b>		
22a. I certify that (I) (the hospital) attended the deceased from <b>17 JUNE</b> , 19 <b>79</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>JUNE 17</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.								
22b. SIGNATURE <b>Mary G. Murphy, MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-17-79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARY J. MURPHY</b>						22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>6-19-79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS</b>		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE OF DEATH <b>JUN 27 1979</b>		
25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

0841



June 17, 1954

RAYMOND

BALTIMORE CITY

THE JOHNS HOPKINS HOSPITAL

RECEIVED  
JUL 1 1954  
J 202

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14421

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles J. McAvoy			2a. DATE OF DEATH MONTH DAY YEAR 6-1-79 0556 <sup>A</sup> M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-17-27	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7b. HOUR 0556 <sup>A</sup> M
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Broker-Estate Sales		12b. KIND OF BUSINESS OR INDUSTRY Real Estate Sales
13a. USUAL RESIDENCE (IF HUSBAND HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Baltimore 13a. COUNTY Calonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ferdinand McAvoy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Crismer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 209-12-2409	17. INFORMANT Mrs. Susanne McAvoy - U. of Md Hosp		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4410 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Shock, hemorrhagic</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Dissecting ascending aortic aneurysm</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 5/31/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/31/79 to 6/1/79, that (I) (we) last saw the deceased alive on 6/1/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)					
22b. SIGNATURE B. Powell MD		DEGREE MD		22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Powell MD		22e. ADDRESS U. of Md. Hosp			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/79	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery-Ellicott City, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Stading Funeral Home 736 Edmondson Ave. Catonsville, Md. 21223		25a. DATE REC'D. BY REGISTRAR JUN 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Male

White

Baltimore, Md.

Baltimore

Baltimore

Ferdinand

Robert

Marie

Charles

No

509-12-309

Rev. Samuel P. Hanson

Buried 6/4/79 St. John's Cemetery-Baltimore City, Md.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 2 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Samuel McClean</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 17 79</b>		2b. HOUR M <b>M</b>
3 SEX <b>Male</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 17 28</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>	
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James McClean</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lyles</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>244-44-0430</b>		17 INFORMANT ADDRESS <b>Arthious McLean 3810 Norfolk Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Dissection of aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1979</b> , to <b>May 13, 1979</b> , that (I) (we) last saw the deceased alive on <b>5.19.79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>G.D. KING</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G.D. KING</b>		ADDRESS <b>818 HALEM AVE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dunn, N.C.</b>		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <b>JUN 19 1979</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUN 19 1979</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(11)

Handwritten signature or initials, possibly "J. Edgar Hoover".

11/11/41

11/11/41

11/11/41

11/11/41

11/11/41

11/11/41



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14423

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Alice M. McCurdy		6 28 1979		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Female	White	APRIL 25 1915	64 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
OHIO	U.S.A.	WIDOWED	DIVORCED	Baltimore City, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	University Hospital (STU)	Housekeeper	At Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MICH		DETROIT	YES	19332 Ash Ton	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
John Henry Easton	Mary True Emery				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	377-36-7462	TERRANCE O ROUKE	8108 Dalesford Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Complications of skeletal injuries					
DUE TO, OR AS A CONSEQUENCE OF					
8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					Head Only
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
6:24 P.M. 5 13 1979		Passenger of auto/bus impact			
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
NOT WHILE AT WORK		street		Route 295 Glen Burnie, Anne Arundel, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		6/29/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN)	COUNTY	STATE
BURIAL	7/3/79	Holy Sepulchre	South Field	Mich	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
EVANS FUNERAL Chapel		JUL 6 1979			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14424	
1. DECEASED NAME (TYPE OR PRINT) <b>John Gregory McDermott</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>28</b> YEAR <b>1979</b>	
1. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>14</b> YEAR <b>1921</b> 6. AGE (IN YEARS) LAST BIRTHDAY <b>67</b> YRS. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. 7c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>28</b> YEAR <b>1979</b> 7d. HOUR <b>9:50</b> P M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner Roofing business</b>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5301 Brabant Road</b>		
14. FATHER'S NAME FIRST <b>late Charles</b> MIDDLE <b>McDermott</b> LAST										15. MOTHER'S MAIDEN NAME FIRST <b>late Mable</b> MIDDLE <b>Redifer</b> LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Glenburnie John G. McDermott Jr. 6500 Panpano Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Multiple Injuries</b> IMMEDIATE CAUSE (a) <b>8150</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b> (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>6:00</b> P.M. MONTH <b>6</b> DAY <b>28</b> YEAR <b>1979</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto/fixed object impact</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>			21f. LOCATION STREET <b>Dogwood Rd.</b> CITY OR TOWN <b>Woodlawn, Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Ann M. Dixon, M.D.</b>						TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>6/29/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>						ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 2, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE			
24. FUNERAL DIRECTOR NAME <b>Harry H. Witzke</b> ADDRESS <b>Columbia Rd Ellicott City Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 5 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Harry H. Witzke</b>		

BP

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 2 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARY HELEN McDONALD</b>			2a DATE OF DEATH MONTH DAY YEAR <b>6 16 78</b>			2b HOUR <b>126 A.M.</b>					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8-20-00</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH PLACE, GIVE STREET AND NUMBER) <b>ST AGNES HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Catonsville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>225 Ridgeway Road</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Samuel McNeely</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridget Kyne</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>214-38-1936</b>		17 INFORMANT <b>Michael D. McDonald, 225 Ridgeway Rd.</b>				ADDRESS <b>21228</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Anteroseptal myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6-15</b> 19 <b>79</b> , to <b>6-16</b> 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>6-16</b> 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.											
22b SIGNATURE <b>Dr. H. S. Huns</b>						DEGREE <b>MD</b>		22c DATE SIGNED <b>06-16-79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. S. Huns</b>						22e ADDRESS <b>ST. Agnes Hosp. 900 Catonsville</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>6/19/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>				
24 FUNERAL DIRECTOR NAME ADDRESS <b>Witzke Catonsville Funeral Home, P.A.</b>						25a DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>		25b REGISTRAR'S SIGNATURE <b>Henry McNeely</b>			

BP

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5 5 5 5 5 5



BALTIMORE CITY

JAN 19 1951

RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 2 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) TIMOTHY JOSEPH McDONALD			2a. DATE OF DEATH MONTH DAY YEAR June 13, 1979		2b. HOUR M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug. 2, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 64	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6802 Linden Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist	12b. KIND OF BUSINESS OR INDUSTRY Murry Corp.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6802 Linden Avenue 21206
14. FATHER'S NAME FIRST MIDDLE LAST Patrick McDonald			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Quinn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-01-7059		17. INFORMANT ADDRESS Lillian A. McDonald (wife) same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Pulmonary Failure</i> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr. 6 w. 3 mo.					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/11</i> 19 <i>79</i> , to <i>6/13</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6/12</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Richards</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>6/14/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richards, M.D.		22e. ADDRESS G.B.M.C. Radiation Therapy-2nd level			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/16/79	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR S. Chumnek Funeral Home, Inc.		9705 Belair Road Balto. Md. 21236		25a. DATE REC'D. BY REGISTRAR JUN 15 1979	25b. REGISTRAR'S SIGNATURE <i>Timothy McCready</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1951



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14427

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Herbert		MIDDLE McDonnald		LAST McDonnald		2a. DATE OF DEATH MONTH DAY YEAR		6 19 79		2b. HOUR 6:35 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR		10 23 22		6. AGE (IN YEARS LAST BIRTHDAY) YRS		56		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driller		12b. KIND OF BUSINESS OR INDUSTRY State Roads		MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hosp.		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS 96 Mary Lane, Apt. 303		13c. CITY OR TOWN Glen Burnie		13d. STATE Md.		13e. COUNTY Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST George E. McDonald		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah M. Knepp		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2		16b. SOCIAL SECURITY NO. 218-16-3698		17. INFORMANT Willmetta McDonald, wife, same as 13		17. ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rapidly Progressive Dementia</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>79</u> , to <u>6/19</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Mark J. Kushner MD		DEGREE		22c. DATE SIGNED 6/19/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark J. Kushner M.D.		22e. ADDRESS University of Maryland Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 June 79		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Vet.		23d. LOCATION CITY OR TOWN COUNTY STATE Crofton AA MD							
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE Rickey McCreedy									

35  
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35  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TSIPI





FOR  
1- STATE  
REGISTRAR

6 #G533 7/16/79 ph (MO)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA L. McGiff			2a. DATE OF DEATH MONTH DAY YEAR 6/27/79			2b. HOUR 3.30 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 24 94		6. AGE IN YEARS LAST BIRTHDAY 84 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutherman		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE BAUER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE DOWNS		16. STREET ADDRESS 2127 HARMAN AVENUE, 21230			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-3907		17. INFORMANT ADDRESS JOHN J. McGiff, 2127 HARMAN AVENUE, 21230			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

hours.

410- DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Atrial clots, inflammatory polyarthritis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/18 1979, to 6/27 1979, that (I) (we) lost saw the deceased alive on 6/27 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sujeta Sapsiri				DEGREE M.D.		22c. DATE SIGNED 6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUJETA SAPSIRI				22e. ADDRESS Lutherman Hospital of Maryland			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-29-79		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14429

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURA M. MCGINLEY			2a. DATE OF DEATH MONTH DAY YEAR June 20, 1979		2b. HOUR 9:30 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sep. 22, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4907 Orville Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Maryland		13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4907 Orville Avenue
14. FATHER'S NAME FIRST MIDDLE LAST John G. Allan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Batchelor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT Laura E. Stecker		ADDRESS 1513 Shore Road 21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yrs</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>cerebral vascular insuff</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>Dec 5-15</u> , 19 <u>79</u> , to <u>6-20</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>5-15</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) we did not view the body after death.					
22b. SIGNATURE <u>Dr. Wyman K. Wong</u>		22c. DATE SIGNED 6/22/79		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Wyman K. Wong, M.D.		22f. ADDRESS 6801 Belair Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/22/79	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	23e. DATE REC'D. BY REGISTRAR JUN 26 1979	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		24b. ADDRESS 3331 Brehms Lane Balto. Md. 21213		24c. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>	

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

(M)

Handwritten notes and diagrams on lined paper, including a large circular diagram with internal lines and text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14430

1. DECEASED NAME (TYPE OR PRINT) <b>LEO</b>		FIRST <b>Leo Vernon McGrain</b> LAST <b>McGRAIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6-2-79</b>		2b. HOUR <b>3:45</b> P.M.	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b>	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Catholic Clergyman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto Co.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John L. McGrain</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mable Woodrow</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-46-0353</b>		17 INFORMANT ADDRESS <b>Mr. Kenneth McGrain- Severn, Maryland</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial rupture</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/2 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CITY</b>			
22a. I certify that (I) (the hospital) attended the deceased from <b>6/2 1979</b> to <b>6/2 1979</b> , that (I) (we) last saw the deceased alive on <b>6/2 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>Patricia Snell</b> DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STATE PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICIA SNELL</b>				22e. ADDRESS <b>MERCY HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto City</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Snell</b>	

BP

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MASS. M.

*[Faint, mostly illegible text and markings covering the main body of the page, possibly bleed-through from the reverse side.]*

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE CLERK OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14431  
REG. NO.

1. STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Thomas Caleb Mc Kean		MONTH DAY YEAR	
3. SEX		2b. HOUR	
male		M	
4. RACE		2c. DATE PRONOUNCED DEAD	
white		MONTH DAY YEAR	
5. DATE OF BIRTH		2d. HOUR	
MONTH DAY YEAR		p. M	
Feb. 21, 44		6 20 1979	
6. AGE (IN YEARS)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
LAST BIRTHDAY		Maryland	
35 YRS		7b. CITIZEN OF WHAT COUNTRY?	
IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		U.S.A.	
IF UNDER 24 HRS.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Baltimore, City		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
University Hospital STU		Elevator Constr.	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE	
U.S. Elev.		Md.	
13b. COUNTY		13c. CITY OR TOWN	
A.A.		GlenBurnie	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
		2101 So. Ritchie Highway	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
Thomas McKean		Bettie Griffin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
yes		1960-63	
17. INFORMANT (wife)		ADDRESS	
Mrs. Ellen M. McKean		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Multiple visceral and skeletal injuries			
DOE TO, OR AS A CONSEQUENCE OF			
(b)			
DOE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR ** MONTH DAY YEAR	
		1:07 P.M. 6/20 1979	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
fell down elevator shaft			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		Building	
21f. LOCATION			
STREET CITY OR TOWN COUNTY STATE			
1100 Wicomico Street, Baltimore City MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE Virginia L. Dolan M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
DATE SIGNED 6/21/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street, Baltimore, MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 25, 1979	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE	
GlenBurnie A.A. Md.			
24. FUNERAL DIRECTOR NAME Address Singleton Funeral Home, GlenBurnie, Md.		25a. DATE REC'D. BY REGISTRAR JUN 22 1979	
		25b. REGISTRAR'S SIGNATURE	

1 4 4 3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 4 3 2

1 DECEASED NAME (TYPE OR PRINT) <b>Daniel</b>			FIRST MIDDLE LAST <b>McKEIVER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>June 14 1979</b>			2b HOUR <b>4:00P M</b>					
3 SEX <b>male</b>			4 RACE <b>Col</b>			5 DATE OF BIRTH MONTH DAY YEAR <b>3 - 3 - 1897</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Florence S.C.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Ret Gas &amp; Ed</b>					
13a STATE <b>Maryland</b>			13b COUNTY <b>Bolto</b>			13c CITY OR TOWN <b>Bolto</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>Henry McKeiver</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sanie ?</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b SOCIAL SECURITY NO. <b>212-05-3390A</b>					
17 INFORMANT ADDRESS <b>Mr Daniel McKeiver 921 Bennett Pl.</b>			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Heart Failure</b>			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			22a I certify that <b>xx</b> this hospital attended the deceased from <b>June 14</b> , 19 <b>79</b> , to <b>June 14</b> , 19 <b>79</b> , that <b>xx</b> (we) lost saw the deceased alive on <b>June 14</b> , 19 <b>79</b> , and that in <b>xx</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>xx</b> (we) (did) (didn't) view the body after death.			22b SIGNATURE <b>Joseph Salvatore</b>		
22c DATE SIGNED <b>6/14/79</b>			22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Salvatore, M.D.</b>			22e ADDRESS <b>c/o Maryland General Hospital</b>			23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>6-20-79</b>		
23c NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Westport Baltimore Md</b>			24 FUNERAL DIRECTOR NAME ADDRESS <b>Joseph C. Rums 2222 W. Nourse</b>			25a DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>			25b REGISTRAR'S SIGNATURE <b>Patricia Kebrady</b>		

MEDICAL CERTIFICATION

BP

1 2 3 4 5 6



June 12 1970

WEDNESDAY

1970

1970

Memorandum General Hospital

Director

one hour

Acute Myocardial Infarction

Consecutive Heart Failure

xx

June 12 1970

70

June 14

June 14 1

xx

xx

xx

One patient under 1 month

Johnson Salvator, S.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 3 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RAY M. McKenzie			2a. DATE OF DEATH MONTH DAY YEAR 06 09 79			2b. HOUR 6:20 P.M.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 02 07 45		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) construction		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RAY Mc Kenzie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN NIGGAIN		16. STREET ADDRESS 2611 Carver Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Evelyn McKenzie 2509 W. Fayette St.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

MASSIVE INTERSTITIAL PNEUMONIA + EMPHYSEMA

135-

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

MASSIVE PULMONARY SARCOIDOSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 06/06/78 to 06/09/79, that (I) (we) lost saw the deceased alive on 06/09/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Fleishman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 06/09/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Fleishman				22e. ADDRESS South Balto General Hosp.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/15/79		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 12 1979	
				25b. REGISTRAR'S SIGNATURE [Signature]			

8 2 4 1 1



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 3 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Redford McMillan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 14 79</i>		2b. HOUR <i>11 55</i> M						
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 20 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>65</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>11 55</i>		8. IF UNDER 24 HRS HOURS MIN. <i>11 55</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.					
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNION MEMORIAL HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i> 13b. COUNTY <i>Balto.</i> 13c. CITY OR TOWN <i>Balto.</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2536 Garrett Avenue</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>John McMillan</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minnie</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>717-09-7860</i>		17. INFORMANT <i>Gertrude McMillan</i>		18. ADDRESS <i>2536 Garrett Avenue</i>					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Falling HOT</i> <i>4590</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Possible reoperation of bed</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 day</i>										20. TERMINAL DISEASE OR CONDITION	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Angina, CHF</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <i>6/12</i> 19 <i>79</i> , to <i>6/14</i> 19 <i>79</i> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <i>6/14</i> 19 <i>79</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <i>Robert Gold</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>6/14/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Gold</i>				22e. ADDRESS <i>Union Memorial Hosp. Calvert + 33rd ST</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/19/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Anne Arundel Co. Md.</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm C March F/H 1101 E. North Ave.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert Gold</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 1 4 4 3 5

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN P. MCTIERNAN			2a. DATE OF DEATH MONTH DAY YEAR 5 26 79		2b. HOUR 11:50 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 27 34		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? ✓	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY --	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 509 S. Durham St.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 145-28-7229		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest. 7100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) pneumonia. (c) S. Lupus Erythematosus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE BEE K. Cuppuswamy MD		DEGREE MD		22c. DATE SIGNED 5/26/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEE K. Cuppuswamy		22e. ADDRESS Church Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/4/79	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUN 8 1979	25b. REGISTRAR'S SIGNATURE History by Brady

2: 5

1998



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14436

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
Annaise Meek		xx 6-16/17-79		1:50A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Female	Black	01-22-1920	59 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.	WIDOWED	Baltimore City, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City	5010 Ready Avenue	Claims Represent	Soc. Sec.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5010 Ready Street 21212	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
William G. Yonge	Eunice C. Young				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	216-12-7515	Miss Karen D. Meek	5010 Ready Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple stab wounds					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		? P.M. 6-16/17-79		subject stabbed by assailant	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		home		5010 Ready Ave. Balto. MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
		M.D. Assistant MEDICAL EXAMINER		6/18/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Ann M. Dixon, M.D.		111 Penn St. Balto., MD			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	June 22, 79	Arbutus Mem. Park	Baltimore County Maryland		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR	
Herbert E. Nutter 3035 W. North Ave,		JUN 19 1979			

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Portland

City of Portland, Oregon

Portland

Portland, Oregon

Portland

Portland

Portland

Portland

Portland, Oregon

Portland

June 22, 1989

Portland

01-82

Portland, Oregon

Portland


 FOR  
1 - STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 4 3 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MELHORN BB DEBORAH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 20 79</b>		2b. HOUR <b>10 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 20 79</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>6 7</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT KEMPLE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DEBORAH MELHORN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>—</b>
17. INFORMANT <b>PARENTS</b>		ADDRESS <b>ABOVE.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> <b>7530</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Probable Potter's syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory Distress syndrome.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20</b> , 19 <b>79</b> , to <b>6/20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>G. Karlowicz</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/20/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY KARLOWICZ</b>		22e. ADDRESS <b>Baltimore City Hosp.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ESSEX BALTO MD</b>
24. FUNERAL DIRECTOR NAME <b>CONNELLY F.H.</b>		ADDRESS <b>300 MACE AVE</b>		25a. FILED <b>JUN 26 1979</b>		

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John P Messina</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>June 28, 1979</b>		2b. HOUR <b>1:25pm</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 25, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electronic Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coast Guard</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Messina</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Pittara</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2 217-20-1017</b>		17. INFORMANT ADDRESS <b>Miss Brenda Messina 13208 Falls Rd. 21030</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure, Peripheral Vascular Disease</b> 4439 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peripheral Vascular Disease</b> (c) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <b>6/19/1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Occlusion of the left superficial femoral artery Arterio-iliac occlusive disease</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1979</b> to <b>June 28, 1979</b> , that (I) (we) last saw the deceased alive on <b>June 28, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William P. Banner</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>June</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William P. Banner</b>		22e. ADDRESS <b>The Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-30-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>5305 Harford Rd. Balto; Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



38

June 22, 1972  
The Donna Hoskins Hospital  
1500 Taylor Avenue  
Baltimore, Maryland

Joseph  
27-22-101  
The Donna Hoskins Hospital

Handwritten notes and signatures, including a large signature at the bottom left.

Handwritten text at the bottom of the page, possibly a date or reference number.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 4 3 9

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Domenic F. Metaglio</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/29/79</b>		2b. HOUR <b>10<sup>45</sup> PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 5 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steel Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>11 Southship Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence Metallo</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Fiortino</b>		16. ADDRESS <b>11 Southship Rd. Balto. MD 21222</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I 110-09-8467</b>		17. INFORMANT <b>Marie V. Metallo</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>7070</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sepsis, pneumonia,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcer, aspiration</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>6/14/79</b> , 19 <b>79</b> , to <b>6/29</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>David Mishkin MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/29/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Mishkin MD</b>		22e. ADDRESS <b>Balto City Hosps</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc</b>			ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Cardiopolymers first  
sepsis, pneumonia  
bacterial infection

David Miskin MD  
David Miskin MD  
Baltimore City Hosp  
X 619179

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				99 22 PE 4 4 4 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROLAND C METCALF			2a. DATE OF DEATH MONTH DAY YEAR JUNE 9 79		2b. HOUR 11:30 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker--Bethlehem Steel		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME William			15. MOTHER'S MAIDEN NAME Cecelia		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-09-0139		
17. INFORMANT Mr. Granville B. Metcalf			17. ADDRESS Baltimore, Md. 21090 108 N. Orchard Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory</u> 1490 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of throat</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/29/79</u> , 19____, to <u>6/9/79</u> , 19____, that (I) (we) lost saw the deceased alive on <u>6/9</u> , 19 <u>79</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <u>Alex C. Bouteneff</u>		DEGREE MD.		22c. DATE SIGNED 6/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEX C. BOUTENEFF		22e. ADDRESS Johns Hopkins			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.	
23d. LOCATION CITY OR TOWN Catonville		COUNTY Baltimore		STATE Md.	
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home		24. ADDRESS 237 E. Patapsco Avenue Baltimore, Md. 21225		25. DATE REC'D. BY REGISTRAR JUN 18 1979	
25b. REGISTRAR'S SIGNATURE <u>Fifty</u>		25c. REGISTRAR'S SIGNATURE <u>Handwritten</u>			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY P METZ			2a DATE OF DEATH MONTH DAY YEAR JUNE 7 1979		2b HOUR 7:48 PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR August 1 1936		6 AGE (IN YEARS LAST BIRTHDAY) 42 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Airpak Corp.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY Frederick	13c. CITY OR TOWN Frederick	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 112 Water Street	
14 FATHER'S NAME FIRST MIDDLE LAST Clarence E. Fogle		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice L. Winpiger			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 30 9403		17 INFORMANT ADDRESS Maryland Francis E. Metz, 112 Water Street, Frederick,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>  1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC OVARIAN CARCINOMA</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>June 7<sup>th</sup></u> , 19 <u>79</u> , to <u>June 7<sup>th</sup></u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 7<sup>th</sup></u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Chandra Nisha</u>		DEGREE		22c. DATE SIGNED <u>June 7/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDRA. NISHA MD		22e. ADDRESS JOHNS HOPKINS HOSP BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 11 1979	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.
24. FUNERAL DIRECTOR Name Address Smith, Padeley, Keeney & Bassford Funeral Home 106 East Church Street, Frederick, Maryland		25. DATE REC'D. BY REGISTRAR JUN 14 1979			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

LIBRARY



11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 4 4 2

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIAN CECILIA MICHAEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 6 79</b>		2b. HOUR <b>2:00A M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 31, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>60</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>---</b> 13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>907 S. FAGLEY ST. # 21224.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN J. FULLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MILANCZ</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-03-2109</b>		17. INFORMANT <b>JOHN J. MICHAEL ;</b> ADDRESS <b>907 S. FAGLEY ST. BALTO., 21224, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Stomach</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinoma of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) this hospital attended the deceased from <b>4-8-79</b> , 19 <b>---</b> , to <b>6-6-79</b> , 19 <b>---</b> , that (ii) (we) last saw the deceased alive on <b>6-5-79</b> , 19 <b>---</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>August D. King Jr.</b>		DEGREE <b>---</b>		22c. DATE SIGNED <b>6-6-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>August D. King Jr.</b>		22e. ADDRESS <b>333 St. Paul Place Balto. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>6515 BOSTON ST. BALTO., MD.</b>		24. FUNERAL DIRECTOR NAME <b>Charles L. Zeller &amp; Son, Inc.</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCurdy</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14443

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Richard Allan Middleton Jr.			2a DATE OF DEATH MONTH DAY YEAR 6-1-79			2b HOUR 1 <sup>11</sup> P.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 28 1979		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 0 4	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT		12b KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 1, Box 401	
13a STATE Md.		13b COUNTY Charles		13c CITY OR TOWN Waldorf			
14 FATHER'S NAME FIRST MIDDLE LAST Richard Allan Middleton, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Susan Combs			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Rt. 1, Box 401 Richard A. Middleton, Sr. Waldorf, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest 7762 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intracranial Haemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Del. C., Prematurity, Hypoxia at birth		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE BASU		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 6/1/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) BASU				22e ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6-4-79		23c NAME OF CEMETERY OR CREMATORY St. Peters Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Waldorf Chas. Md.	
24 FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md.				25a DATE REC'D. BY REGISTRAR JUN 5 1979		25b REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31.21.21



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

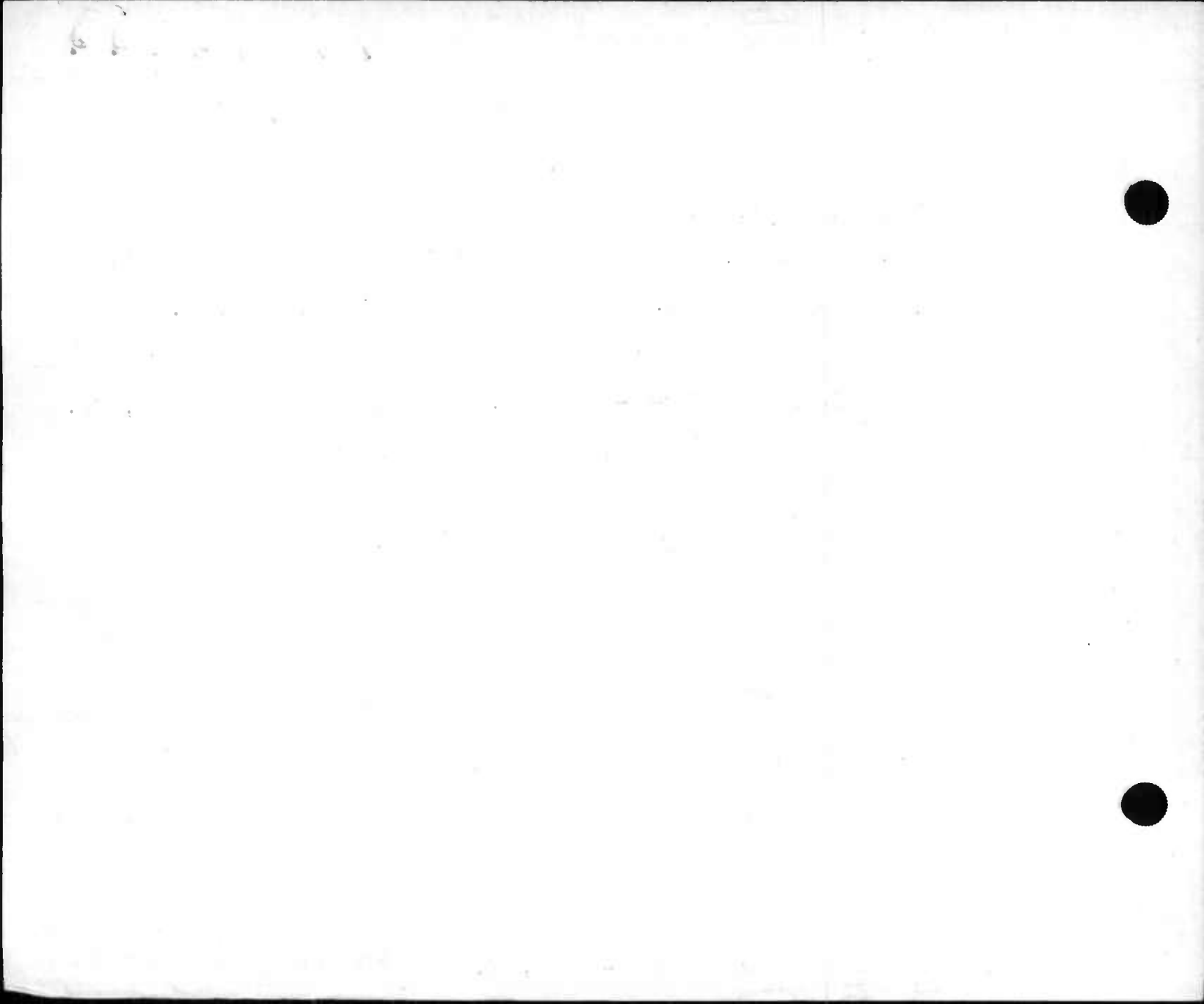
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Helen Miehl</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 15, 1979</b>		2b. HOUR <b>11:15p</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 23, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Plumville, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Penna.</b>		13b. COUNTY <b>Warren</b>		13c. CITY OR TOWN <b>Warren</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Corbett Hockman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruby Ann Stiles</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Mr. Grant Green (son) Warren, Pa.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b> 2060 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarction</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11:15pm</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> , 19 <b>79</b> , to <b>6/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Frank L. Douglas</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/15/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank L. Douglas</b>				22e. ADDRESS <b>Johns Hopkins Hospital Dept Medicine</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/19/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warren Warren Penna.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>E. Barnes Fleming Funeral Service-Benson, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>		

TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14445

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles J. MILLER</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 11 79</i>			2b. HOUR <i>952<sup>AM</sup></i>				
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 23 37</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>41</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bartender</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF HUSBAND HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i>		13c. COUNTY <i>Baltimore</i>		13d. CITY OR TOWN <i>Baltimore</i>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <i>1707 St. Paul St.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Miller</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillian ?</i>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				
16a. (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. <i>215-34-9456</i>			17. INFORMANT ADDRESS <i>BCH. Records, 4940 Eastern Ave 24</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>585- Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CHRONIC RENAL Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>4/1/79</i> to <i>6/1/79</i> , that (I) (we) lost saw the deceased alive on <i>6/1/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Henry Silverman</i>			DEGREE <i>MD</i>			22c. DATE SIGNED <i>6/4/79</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HENRY SILVERMAN</i>			22e. ADDRESS <i>BALTIMORE CITY Hospital</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>6-13-79</i>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Anatomy Board of Maryland</i>			ADDRESS <i>Baltimore, Md.</i>			25a. REC'D BY REGISTRAR <i>JUN 18 1979</i>		25b. REC'D BY REGISTRAR <i>Henry Silverman</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PHESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14446			
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD Wilson MILLER</b>										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY YEAR 6 25 19 79		2b. HOUR 6:50 P M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1936		6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 25 19 79			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital			12a. USUAL OCCUPATION (TYPE OF WORK) Auto Wrecker wrecker constr.			12b. KIND OF BUSINESS AUTO INDUSTRY auto construct				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Virginia		13b. COUNTY Rockingham		13c. CITY OR TOWN Broadway		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 3					
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Detta Beatrice Smith unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. Korea 223 40 1831		16c. INFORMATION ADDRESS Grand Old Funeral Home, Broadway, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries with complications IMMEDIATE CAUSE (a) 9/16 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 3 P.M. 6-21-19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Junk car rolled over & pinned victim.							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) junk yard		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 800 Gorsuch Rd. Westminster Carroll Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Normal causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>H R Guard</i>						TITLE (SPECIFY) Assistant			DATE SIGNED 6-26-79				
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.						ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/28/79		23c. NAME OF CEMETERY OR CREMATORY Strickler Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Broadway, Rockingham, Virginia					
24. FUNERAL DIRECTOR SLACK Funeral Home, Ellicott City, Maryland 21043						25a. DATE REC'D. BY REGISTRAR JUN 29 1979		25b. REGISTRAR'S SIGNATURE <i>Patrick McCreedy</i>					

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14447

1. DECEASED NAME (TYPE OR PRINT) JOHN EDGAR MILLER			2a. DATE OF DEATH MONTH DAY YEAR 6 13 79			2b. HOUR 1:00 AM	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 09 29 16		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
13a. STATE MD		13b. COUNTY PR. GEO.		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 12665 HEMING LAKE							
14. FATHER'S NAME FIRST MIDDLE LAST XXXXXXXXXX James N. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST XXXXXXXXXX Lena Rusmisl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 226 18 2753		17. INFORMANT ADDRESS OLD CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST, HYPOTENSION, ?SEPSIS 2051 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CHRONIC MYELOCYTIC LEUKEMIA, BLAST CRISIS DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 HRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) UPPER GI BLEED							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 12, 19 79, to JUNE 13, 19 79, that (I) (we) last saw the deceased alive on JUNE 13, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan M. Shorofsky MD				DEGREE MD		22c. DATE SIGNED 6/13	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN M. SHOROFSKY, MD				22e. ADDRESS 22 S. GREENE ST., BALTIMORE, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 JUN 79		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem Gdns		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, MD	
24. FUNERAL DIRECTOR Robert G. Beall Funeral Home NAME ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 19 1979			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. Page 16 should be filed within 72 hours after death. Page 17 should be filed within 72 hours after death. Page 18 should be filed within 72 hours after death. Page 19 should be filed within 72 hours after death. Page 20 should be filed within 72 hours after death. Page 21 should be filed within 72 hours after death. Page 22 should be filed within 72 hours after death. Page 23 should be filed within 72 hours after death. Page 24 should be filed within 72 hours after death. Page 25 should be filed within 72 hours after death. Page 26 should be filed within 72 hours after death. Page 27 should be filed within 72 hours after death. Page 28 should be filed within 72 hours after death. Page 29 should be filed within 72 hours after death. Page 30 should be filed within 72 hours after death. Page 31 should be filed within 72 hours after death. Page 32 should be filed within 72 hours after death. Page 33 should be filed within 72 hours after death. Page 34 should be filed within 72 hours after death. Page 35 should be filed within 72 hours after death. Page 36 should be filed within 72 hours after death. Page 37 should be filed within 72 hours after death. Page 38 should be filed within 72 hours after death. Page 39 should be filed within 72 hours after death. Page 40 should be filed within 72 hours after death. Page 41 should be filed within 72 hours after death. Page 42 should be filed within 72 hours after death. Page 43 should be filed within 72 hours after death. Page 44 should be filed within 72 hours after death. Page 45 should be filed within 72 hours after death. Page 46 should be filed within 72 hours after death. Page 47 should be filed within 72 hours after death. Page 48 should be filed within 72 hours after death. Page 49 should be filed within 72 hours after death. Page 50 should be filed within 72 hours after death. Page 51 should be filed within 72 hours after death. Page 52 should be filed within 72 hours after death. Page 53 should be filed within 72 hours after death. Page 54 should be filed within 72 hours after death. Page 55 should be filed within 72 hours after death. Page 56 should be filed within 72 hours after death. Page 57 should be filed within 72 hours after death. Page 58 should be filed within 72 hours after death. Page 59 should be filed within 72 hours after death. Page 60 should be filed within 72 hours after death. Page 61 should be filed within 72 hours after death. Page 62 should be filed within 72 hours after death. Page 63 should be filed within 72 hours after death. Page 64 should be filed within 72 hours after death. Page 65 should be filed within 72 hours after death. Page 66 should be filed within 72 hours after death. Page 67 should be filed within 72 hours after death. Page 68 should be filed within 72 hours after death. Page 69 should be filed within 72 hours after death. Page 70 should be filed within 72 hours after death. Page 71 should be filed within 72 hours after death. Page 72 should be filed within 72 hours after death. Page 73 should be filed within 72 hours after death. Page 74 should be filed within 72 hours after death. Page 75 should be filed within 72 hours after death. Page 76 should be filed within 72 hours after death. Page 77 should be filed within 72 hours after death. Page 78 should be filed within 72 hours after death. Page 79 should be filed within 72 hours after death. Page 80 should be filed within 72 hours after death. Page 81 should be filed within 72 hours after death. Page 82 should be filed within 72 hours after death. Page 83 should be filed within 72 hours after death. Page 84 should be filed within 72 hours after death. Page 85 should be filed within 72 hours after death. Page 86 should be filed within 72 hours after death. Page 87 should be filed within 72 hours after death. Page 88 should be filed within 72 hours after death. Page 89 should be filed within 72 hours after death. Page 90 should be filed within 72 hours after death. Page 91 should be filed within 72 hours after death. Page 92 should be filed within 72 hours after death. Page 93 should be filed within 72 hours after death. Page 94 should be filed within 72 hours after death. Page 95 should be filed within 72 hours after death. Page 96 should be filed within 72 hours after death. Page 97 should be filed within 72 hours after death. Page 98 should be filed within 72 hours after death. Page 99 should be filed within 72 hours after death. Page 100 should be filed within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MADELEINE C. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 28 79</b>		2b. HOUR <b>7:00 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 14, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S. Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>204 Linden Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilbur L. Wheeler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva May Carre</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-01-0621</b>		17. INFORMANT ADDRESS <b>Margaret K. Mc Mahon, Same as #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 27</b> , 19 <b>79</b> , to <b>JUNE 28</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dexter T. Todmann, M.D.</b>				22c. DATE SIGNED <b>6/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dexter T. Todmann, M.D.</b>		22e. ADDRESS <b>Sinai Hosp of Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-2-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		25. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>			

1990



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14449

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SARA</b>		FIRST <b>MILLSTONE</b>		MIDDLE <b>MILLSTONE</b>		LAST <b>MILLSTONE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>June 3/79</b>		2b. HOUR <b>10 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 1, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>79</b>		IF UNDER 24 HRS <b>10 A.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3012 FALLSTAFF MANOR CT. 21209</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>REV. SAMUEL LOUIS GOLDBERG</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>REBECCA BOONE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-44-5554</b>		17. INFORMANT <b>J. MAX MILLSTONE</b> <b>6611 AMLEIGH RD. #21209</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6/3 79</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>May 29 1979</b> to <b>6/3 79</b> , that (I) (we) last saw the deceased alive on <b>May 29 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>MILTON KIRSH</b>				DEGREE <b>KIRSH</b>				22c. DATE SIGNED <b>6/3/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Metropolitan</b>				22e. ADDRESS <b>3737 Clarks Lane</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>JUNE 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14450

1. STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH ESTIMATED	
HAMPTON MIMS		6 12 79	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
male	black	2 8 04	75 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
S.C.	USA	WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	829 E. Coldspring Lane		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS
Md.		Balto.	829 E. Coldspring Lane
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
Hampton	Hattie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	217-03-9180	Gwendolyn Burke	2924 Craigton La.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm of circle of Willis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		DATE SIGNED 6/13/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN) COUNTY STATE
Burial	6/18/79	Md. Nat. Mem. Pk.	Laurel, Md.
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Wm C March F/H	1101 E. North Ave.		JUN 15 1979

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1901 E. Colburn

1901 E. Colburn

1901 E. Colburn



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 4 4 5 1 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
James		R.		Mitchell				6/5/79	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		Black		4 18 03		76		7:05 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.		USA				Balto. City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Balto.		Baltimore City Hosp.							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.				Balto.				510 E. 36th St.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Ben Mitchell		Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		213-09-3877		Junius Mitchell 2341 W. North Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Lung Ca. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/1/79, 19 79, to 6/5/79, 19 79, that (I) (we) last saw the deceased alive on 6/5/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Walfredo J. Leon		6/5/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
WALFREDO J. LEON		Baltimore City Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6/11/79		Mt. Calvary Cem.		Anne Arundel Co., Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm C March F/H		1101 E. North Ave.				JUN 11 1979			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14452

1. FOR  
STATE  
REGISTER

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM MORRELL MITCHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 8 79</b>			2b. HOUR <b>7:30</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 16 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>	
						12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>2901 E. Northern Pkwy</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Mitchell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Iva Talkington</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>234-10-0071</b>		17. INFORMANT <b>Justine Nelson, 2901 E. Northern Pkwy</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic lung ca</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/8 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <b>WILLIAM</b> attended the deceased from <b>5/12</b> 19 <b>79</b> , to <b>6/8</b> 19 <b>79</b> , that <b>he</b> saw the deceased alive on <b>6/8</b> 19 <b>79</b> , and that in my <b>own</b> opinion death occurred on the date and hour and from the causes stated above, <b>and</b> I <b>did not</b> view the body after death.							
22b. SIGNATURE <b>Sybil White MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SYBIL WHITE</b>		22e. ADDRESS <b>SINAI HOSP BALTIMORE</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>June 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brick Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clarksburg, Harrison, W. Va.</b>	
24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McBrine</b>	
6009 Harford Rd., Balto., Md. 21214							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14453

FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) JULIUS MITNICK <i>Mitnick Julius</i>		2a. DATE OF DEATH MONTH DAY YEAR 6 14 79 2b. HOUR 9:05 P.M.	
3 SEX MALE	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 4 7 19	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	6 AGE (IN YEARS LAST BIRTHDAY) 60 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Baltimore	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
12a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST EDWIN MITNICK		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN WEINER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-03-6446	
17 INFORMANT MRS. BERNICE MITNICK		18. DATE OF OPERATION 19. CONDITION FOR WHICH OPERATION WAS PERFORMED	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>1940</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TERMINAL CONDITION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTATIC ADRENAL CARCINOMA</u> <u>1973</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
20a. DATE OF OPERATION		20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-14-79</u> to <u>6-14-79</u> , that (I) (we) last saw the deceased alive on <u>6-14-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Nentey</i> 9135 MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 6/14/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) VERSTEEG	
22e. ADDRESS SINAI HOSPITAL BALT. MD.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE JUNE 17, 1979		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215	
25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE <i>Robert McBrady</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

Items 4,7b g533 7/12/79 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 5 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Freydoon G. MOGH BELI</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-19-79</b>                  |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>5:51</b> AM                                                           |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b><br><del>Indian</del>                                              |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 3, 1938</b>                                                                                                  |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b>                                         |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                  |                                                                                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Iran</b>                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Iran</b><br><del>USA</del>                             |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.             |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Physician</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>              |                                                                                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                           | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Towson</b>                                             |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                  | 13e. STREET ADDRESS<br><b>8415 Bellona Lane</b>                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mohamad Djavad Moghbeli</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                           |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Zinat Ganszhashi</b>                                                                                    |                                                                                |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO<br><b>047-42-0436</b>                                             |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Janet S. Moghbeli Same as # 13</b>                                                                                      |                                                                                |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>INTRACTABLE CONGESTIVE HEART FAILURE</b><br><b>3989</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Rheumatic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                          |  |                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                |                                                                                      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |  |                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                               |  |                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>June 12 19 79</b> to <b>June 19 19 79</b> , that (1) (we) lost<br>saw the deceased alive on <b>June 19 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did not) view the body after death.                                                                    |  |                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Thomas M. Walsh MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                             |  |                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>6-19-79</b>                               |                                                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS M. WALSH M.D.</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                           |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                 |                                                                                      |                                                                                                 |                                                                  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                           | 23b. DATE<br><b>6/26/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                                      |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Tehran Iran</b> |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson Md. (USA)</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                           |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>                            |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Hardy</b>                                            |                                                                  |                                                                                                                                       |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**A**



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 5 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               | 2b. HOUR                                                                       |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                      |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               | 2b. HOUR                                                                       |                                   |
| THEODORE W. MOMMERS                                                                                                                                                                                                                                                                                                   |                                                                                                        | June 20, 1979                                                                                                                                            |                                                               | 8:35 A.M.                                                                      |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR                                                                |                                   |
| Male                                                                                                                                                                                                                                                                                                                  | White                                                                                                  | 2 8 09                                                                                                                                                   | 70 YRS                                                        | MONTHS DAYS HOURS MIN.                                                         |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                   |
| Conn.                                                                                                                                                                                                                                                                                                                 | USA                                                                                                    |                                                                                                                                                          |                                                               | BALTIMORE CITY MD.                                                             |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE                                                                                                                                                                                                                                                                                                             | UNION MEMORIAL HOSPITAL                                                                                |                                                                                                                                                          | Engineer                                                      |                                                                                | Aerospace                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                          | 13b. CITY OR TOWN                                                                                      | 13c. INSIDE CITY LIMITS?                                                                                                                                 | 13d. STREET ADDRESS                                           |                                                                                |                                   |
| Md.                                                                                                                                                                                                                                                                                                                   | Balto.                                                                                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 | 10 Aighburth Road                                             |                                                                                |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                          |                                                               |                                                                                |                                   |
| Richard                                                                                                                                                                                                                                                                                                               | Mommers                                                                                                |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                     | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT ADDRESS                                                                                                                                    |                                                               |                                                                                |                                   |
| Unkn.                                                                                                                                                                                                                                                                                                                 | 213-09-9095                                                                                            |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| PART I. DEATH WAS CAUSED BY                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| IMMEDIATE CAUSE (a) cardio pulmonary arrest                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| (b) massive left cerebrovascular accident 24 hrs.                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| (c)                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY?                                                                  |                                   |
|                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                   |
|                                                                                                                                                                                                                                                                                                                       |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                               |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                       |                                                                                                        | P.M. 19                                                                                                                                                  |                                                               |                                                                                |                                   |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                  |                                                                                                        | 21e. PLACE OF INJURY                                                                                                                                     |                                                               | 21f. LOCATION                                                                  |                                   |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                     |                                                                                                        | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]                                                                                                           |                                                               | STREET CITY OR TOWN COUNTY STATE                                               |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19, 19 79, to 6/20, 19 79, that (I) (we) lost saw the deceased alive on 6/20, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                        |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | 22c. DATE SIGNED                                                               |                                   |
| Paul Gertler                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                               | 6/20/79                                                                        |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                 |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               |                                                                                |                                   |
| PAUL GERTLER, M.D.                                                                                                                                                                                                                                                                                                    |                                                                                                        | UNION MEMORIAL HOSPITAL                                                                                                                                  |                                                               |                                                                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                             |                                                                                                        | 23b. DATE                                                                                                                                                |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                   |
| Removal                                                                                                                                                                                                                                                                                                               |                                                                                                        | 6/20/79                                                                                                                                                  |                                                               |                                                                                |                                   |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                  |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                               | 25b. REGISTRAR'S SIGNATURE                                                     |                                   |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                          |                                                                                                        | JUN 27 1979                                                                                                                                              |                                                               | History McCreedy                                                               |                                   |
| Anatomy Board                                                                                                                                                                                                                                                                                                         |                                                                                                        | Balto., Md.                                                                                                                                              |                                                               |                                                                                |                                   |

2000 11 11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 5 6

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Clara H. Montgillion</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 20 79</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>P. M.</b>                                                                                                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>White</b>                                                                                                                       |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 9, 1925</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54 years</b> YRS                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1253 Haverhill Road 21229</b> |                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY                                                                                                                                   |                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Koper</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes Barnas</b>                                                                          |                                                        | 16. SOCIAL SECURITY NO.<br><b>219-12-6882</b>                                                                                                               |  |                                                                                                                            |  |
| 17. INFORMANT<br>ADDRESS<br><b>Rd. 21229</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. NAME OF DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                              |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1889</b> IMMEDIATE CAUSE (a) <b>Carcinoma of bladder with</b><br><b>Generalized Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> |  |                                                                                                                                               |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>May 1974</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of bladder</b>                                                                  |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 6/19/79</b> to <b>June 20 19 79</b> , that (I) (we) last saw the deceased alive on <b>6/19/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                        |  |                                                                                                                                               |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Barclay Pass</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>M.D.</b>                                                                                                                         |                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>6/20/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Pass, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                        | 22e. ADDRESS<br><b>4001 Wilkens Avenue</b>                                                                                                                  |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>6/23/79</b>                                                                                                                   |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Balto., Md. 21229</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31



General and Special Instructions

Handwritten notes and signatures, including the word "March" and various illegible scribbles.

Handwritten notes and signatures at the bottom of the page, including the word "March" and various illegible scribbles.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14457

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                     |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 2a. DATE KNOWN OF DEATH                                                                                                             |                                                                                                                                                          | MONTH DAY YEAR                                                                             |                                      | HOUR                                                                             |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | FIRST MIDDLE LAST                                                                                                                   |                                                                                                                                                          | MONTH DAY YEAR                                                                             |                                      | HOUR                                                                             |                                              |
| Gary L. Monroe                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                     |                                                                                                                                                          | 6 15 79                                                                                    |                                      | M                                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                 | 5. DATE OF BIRTH (MONTH DAY YEAR)                                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                          | IF UNDER 1 YR                                                                              | IF UNDER 24 HRS                      | 7c. DATE PRONOUNCED DEAD                                                         | 2d. HOUR                                     |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                   | Black                                                                                                   | 1 28 58                                                                                                                             | 21 YRS                                                                                                                                                   | MONTHS DAYS                                                                                | HOURS MIN                            | 6 15 79                                                                          | 6:00 A M                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |                                                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                                  |                                              |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                    | USA                                                                                                     |                                                                                                                                     |                                                                                                                                                          |                                                                                            | Baltimore City, MD.                  |                                                                                  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                     |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                              |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              | Union Memorial Hospital                                                                                 |                                                                                                                                     |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN                                                                                                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS                                                                        |                                      |                                                                                  |                                              |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | Balto.                                                                                                                              |                                                                                                                                                          | 1551 Stonewood Rd.                                                                         |                                      |                                                                                  |                                              |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                                                        |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
| Sherman Monroe                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | Lillian H. Powell                                                                                                                   |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 16b. SOCIAL SECURITY NO.                                                                                                            |                                                                                                                                                          | 17. INFORMANT ADDRESS                                                                      |                                      |                                                                                  |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 212-72-9139                                                                                                                         |                                                                                                                                                          | Brenda Williams 1551 Stonewood Rd.                                                         |                                      |                                                                                  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shotgun Wound of Right Side of Chest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                   |                                                                                                         |                                                                                                                                     |                                                                                                                                                          |                                                                                            |                                      |                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                                     |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                   |                                                                                                                                                          |                                                                                            |                                      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MIN <input checked="" type="checkbox"/> MONTH DAY YEAR 11 P.M. 6 14 79 |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot |                                      |                                                                                  |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                             |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home                                                                    |                                                                                                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1551 Stonewood Rd., Baltimore Md.           |                                      |                                                                                  |                                              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                         |                                                                                                                                     |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
| ACTUAL SIGNATURE Virginia L. Dolan                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | TITLE (SPECIFY) Assistant                                                                                                           |                                                                                                                                                          | M.D. MEDICAL EXAMINER                                                                      |                                      | DATE SIGNED 6/15/79                                                              |                                              |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | ADDRESS 111 Penn Street                                                                                                             |                                                                                                                                                          |                                                                                            |                                      |                                                                                  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                       | 23b. DATE 6/20/79                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY Church Cem.                                                                                      |                                                                                                                                                          | 23d. LOCATION CITY OR TOWN COUNTY STATE Elizabethtown, N.C.                                |                                      |                                                                                  |                                              |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | ADDRESS 1101 E. North Ave.                                                                                                          |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR JUN 18 1979                                                  |                                      | 25b. REGISTRAR'S SIGNATURE                                                       |                                              |

100



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14458

FOR  
1- STATE  
REGISTRAR

|                                                                                    |                                            |                                                                                                                                          |                                                                                                                                                             |                                          |                                                                    |                                                                    |                                                                                                 |  |
|------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lillian H. Monroe</b>                    |                                            |                                                                                                                                          | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 14 19 79</b>                                             |                                          |                                                                    | 2b. HOUR<br><b>11:40</b>                                           |                                                                                                 |  |
| 3. SEX<br><b>Female</b>                                                            | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 31 35</b>                                                                                    | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>43</b> YRS.                                                                                                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.                                                   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 14 19 79</b>    | 2d. HOUR<br><b>11:40</b>                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |                                                                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                          |                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD. |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |                                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1551 Stonewood Road</b> |                                                                                                                                                             |                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)      |                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. STATE<br><b>Md.</b>                                                           |                                            |                                                                                                                                          | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                |                                          | 13c. CITY OR TOWN<br><b>1551 Stonewood Rd.</b>                     |                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Worwick L. McCoy</b>                  |                                            |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Earlene S. Powell</b>                                                                                   |                                          |                                                                    |                                                                    |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b> |                                            |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>240-54-4093</b>                                                                                                              |                                          | 17. INFORMANT ADDRESS<br><b>Brenda Williams 1551 Stonewood Rd.</b> |                                                                    |                                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY  
**Shotgun Wound of Back**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

9654 IMMEDIATE CAUSE (a) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. \_\_\_\_\_  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF \_\_\_\_\_  
(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|                                                                                                                         |  |                                                                                          |  |                                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                        |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR <del>AM</del> MONTH DAY YEAR<br><b>11:00 P.M. 6 14 19 79</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot</b> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1551 Stonewood Rd., Baltimore Md.</b>        |  |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL SIGNATURE *Virginia L. Dolan* M.D. TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **6/15/79**  
EXAMINER'S NAME (TYPE OR PRINT) **Virginia L. Dolan, M.D.** ADDRESS **111 Penn Street**

|                                                                                   |                             |                                                          |                                                                          |
|-----------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------|--------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                        | 23b. DATE<br><b>6/20/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elizabethtown, N.C.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C. March F/H 1101 E. North Ave.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                         |

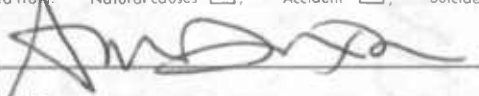





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14459

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                          |                                            |                                                                                                                                                             |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sherman Monroe</b>                                                                                                                                                                                                                                                                                                                                                                  |                         | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY 6 YEAR 1979                                                     |                                            | 7b. HOUR<br>M 11:30 P                                                                                                                                       |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH 2 DAY 26 YEAR 30                                                                                               | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 49 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               | IF UNDER 24 HRS.<br>HOURS MIN                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                                                      |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1551 Stonewood Road</b> |                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>12b. KIND OF BUSINESS OR INDUSTRY                                                          |                                              |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                          |                                            |                                                                                                                                                             |                                              |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 13b. COUNTY<br><b>Balto.</b>                                                                                                             |                                            | 13c. STREET ADDRESS<br><b>1551 Stonewood Road</b>                                                                                                           |                                              |
| 14. FATHER'S NAME<br><b>John M. Monroe</b>                                                                                                                                                                                                                                                                                                                                                                                    |                         | 15. MOTHER'S MAIDEN NAME<br><b>Lessie Robinson</b>                                                                                       |                                            |                                                                                                                                                             |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                            |                         | 16b. SOCIAL SECURITY NO.<br><b>239-40-7916</b>                                                                                           |                                            | 17. INFORMANT<br><b>Brenda William</b><br>ADDRESS<br><b>1551 Stonewood St.</b>                                                                              |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Shotgun Wounds of Chest &amp; Right Groin</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                   |                         |                                                                                                                                          |                                            |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                          |                                            |                                                                                                                                                             |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |                                            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |                                              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                        |                         | 21b. TIME OF INJURY<br>HOUR <b>11</b> P.M. MONTH <b>6</b> DAY <b>14</b> YEAR <b>79</b>                                                   |                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot</b>                                                        |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                       |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                                                               |                                            | 21f. LOCATION<br>STREET <b>1551 Stonewood Rd.,</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE <b>Md.</b>                                         |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                          |                                            |                                                                                                                                                             |                                              |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                       |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>                                                                                                 |                                            | DATE SIGNED <b>6/15/79</b>                                                                                                                                  |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                               |                         | ADDRESS<br><b>111 Penn Street</b>                                                                                                        |                                            |                                                                                                                                                             |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                    |                         | 23b. DATE<br><b>6/20/79</b>                                                                                                              |                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>                                                                                                    |                                              |
| 23d. LOCATION<br>CITY OR TOWN <b>Elizabethtown, N.C.</b> COUNTY <b>N.C.</b> STATE <b>N.C.</b>                                                                                                                                                                                                                                                                                                                                 |                         | 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. March F/H</b>                                                                                   |                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |                                              |
| ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 25b. REGISTRAR'S SIGNATURE<br>                      |                                            |                                                                                                                                                             |                                              |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH - 17  
(VR A15 ME (5))  
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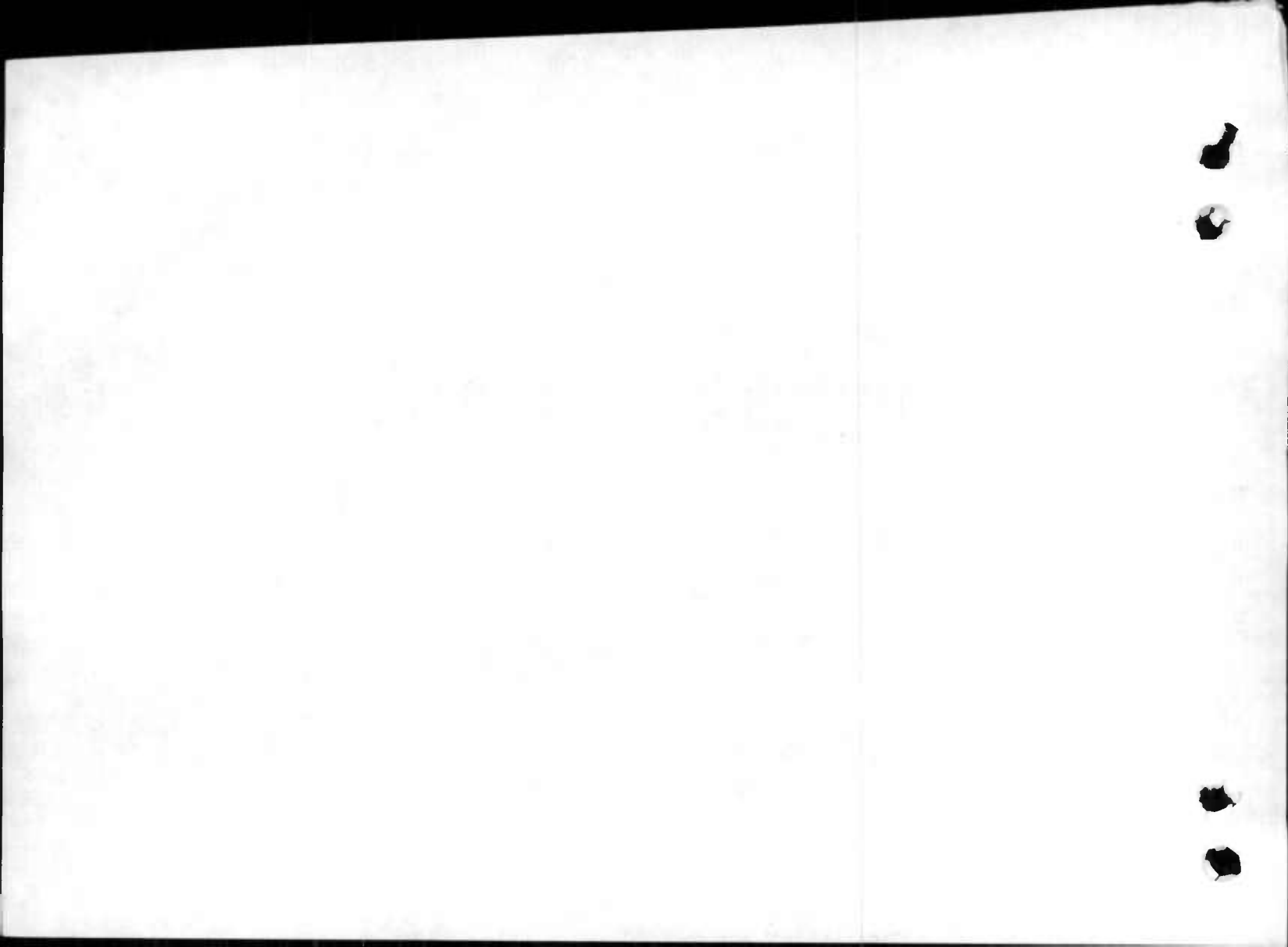


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June, 79

City

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14461

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROSLYN M. MOODY</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 18 79</b> |                                                                                                                                                             |  | 2b. HOUR<br>MIN.<br><b>5:35 P.</b>                                                                                                    |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                           |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 11 1901</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS HOURS MIN.<br><b>77</b>                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                     |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD                                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postmistress</b>                                               |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                     |                                                       | 13c. CITY OR TOWN<br><b>Westminster</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES P Woods</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Azzie Hanlon</b>                                                              |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                               |  |                                                                                                                                       |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-09-2355</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>121 Emberton Rd<br/>May Morris Owings Mills, MD 21117</b>                                          |                                                       |                                                                                                                                                             |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CHRONIC RENAL FAILURE</b><br><b>5900</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Ch. pyelonephritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ruptured</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sev. yrs.</b> |  |                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>Bleeding Diathesis - ; Intra Peritoneal Bleed; Anemia Chronic, colon.</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |                                                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> 19 <b>79</b> , to <b>6/18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                |  |                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Veneranda G. Barnes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VENERANDA G. BARNES</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |                                                       | 22e. ADDRESS<br><b>NORTH CHARLES GEN. HOSP</b>                                                                                                              |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>6-21-79</b>                                                                                                       |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EVERGREEN</b>                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg Carroll MD</b>                                                             |  |
| 24. FUNERAL DIRECTOR<br><b>Robert Kyle Pratt Jr Westminster, Md</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                         |  |                                                                                                                                       |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  | 7 9 1 4 4 6 2                                                                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                         |  | REG. NO.                                                                                                                   |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>LOTTIE VIOLA MOORE                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                            |  |                                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6-19-79                                            |  | 2b. HOUR<br>10 <sup>45</sup> M                                                                                                             |  |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>White                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 27, 1920                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 years                                            |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                              |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT SUCH A PLACE, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Theater Manager    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Theater<br>Hollywood                                                                                  |  |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                               |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                                                                   |  |
| 13c. CITY OR TOWN<br>Arbutus                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>5509 Oregon Avenue 21227                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Moore                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hassie Harvelle                                                                                         |  |                                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>410-34-3753                                                                                                                  |  | 17. INFORMANT<br>ADDRESS Balto., Md. 21229<br>Mr. James Moore, 1228 Maiden Choice Lane |  |                                                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>met. ca</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>small cell ca of lung</u> |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>C.H.F.</u>                                                                                                                                                                                                                                               |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |  |                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |  |                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |  |                                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 19 <u>79</u> , to <u>6-19</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>David Strobel</u>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  |                                                                                                                                                          |  | DEGREE<br>M.D.                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID STROBEL                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  |                                                                                                                                                          |  | 22e. ADDRESS                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                            |  | 23b. DATE<br>6/23/79                                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard County, Maryland                                                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                            |  |                                                                                                                                                          |  | ADDRESS<br>4107 Wilkens Ave.                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><u>H. K. Brady</u>                                                                           |  |

YALOWITZ, J. 1991.

JOURNAL OF THE ATMOSPHERIC SCIENCES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

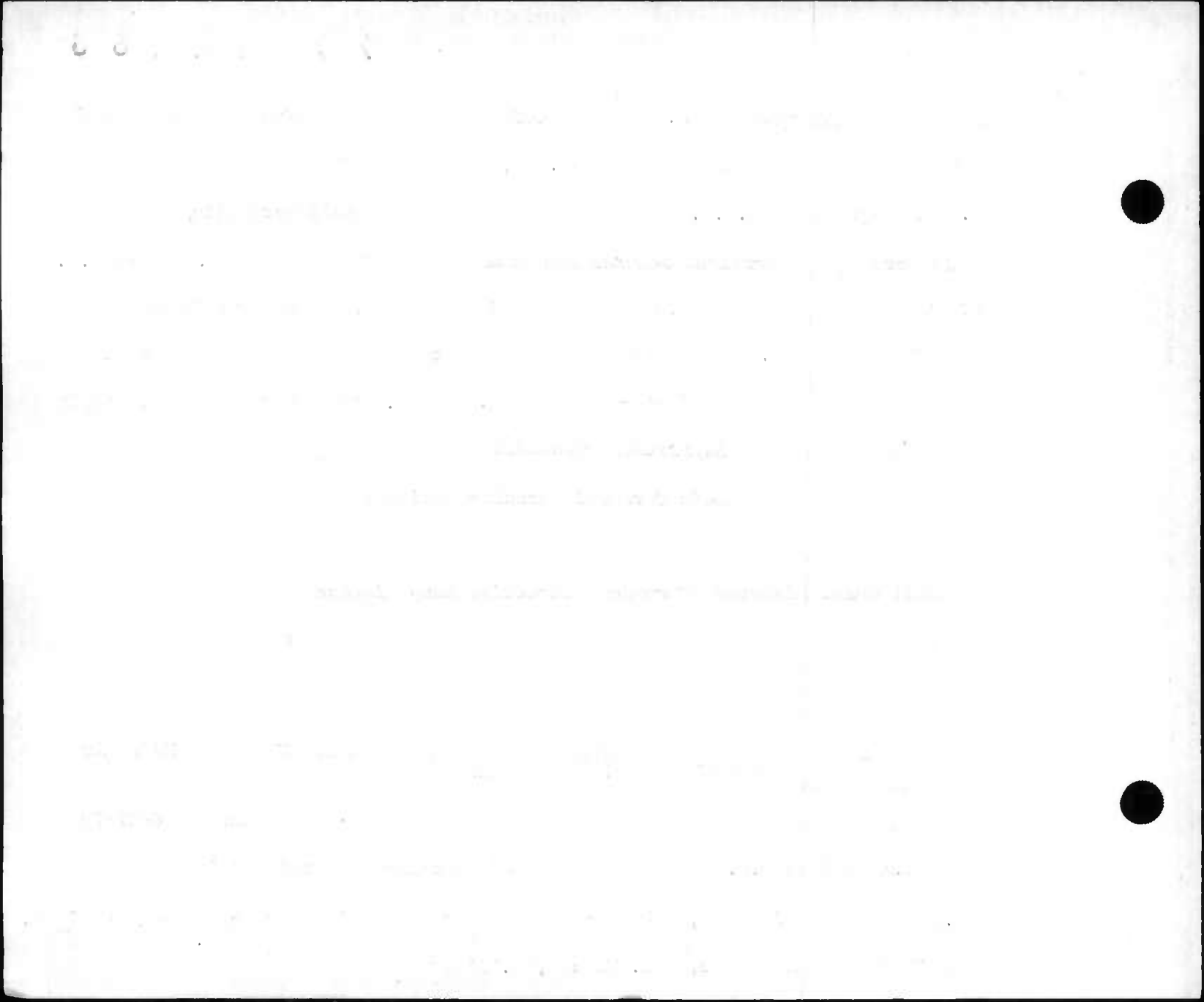
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 14463

|                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH                                                                                                                          |  | 2b. HOUR                                                                                                                                                |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                    |  | 3 SEX                                                                                                                                      |  | 4 RACE                                                                                                                                                  |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                  |  | Male                                                                                                                                       |  | White                                                                                                                                                   |  |
| Lawrence J. MORAN                                                                                                                                                                                                                                                                                                                                                                                  |  | 5 DATE OF BIRTH                                                                                                                            |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                                          |  |
| MONTH DAY YEAR                                                                                                                                                                                                                                                                                                                                                                                     |  | Nov. 21, 1906                                                                                                                              |  | 72 YRS.                                                                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                               |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| W. Virginia                                                                                                                                                                                                                                                                                                                                                                                        |  | U.S.A.                                                                                                                                     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                           |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                          |  | Maryland General Hospital                                                                                                                  |  | Repairman Balto. & Ohio R.R.                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                       |  | 13b. INSIDE CITY LIMITS?                                                                                                                   |  | 13c. STREET ADDRESS                                                                                                                                     |  |
| 13a STATE 13b COUNTY 13c CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 1313 Herkimer Street                                                                                                                                    |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                   |  | 15 MOTHER'S MAIDEN NAME                                                                                                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                           |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                  |  | FIRST MIDDLE LAST                                                                                                                          |  | 16b SOCIAL SECURITY NO.                                                                                                                                 |  |
| John P. Moran                                                                                                                                                                                                                                                                                                                                                                                      |  | Lillie Paire                                                                                                                               |  | 225-09-9514                                                                                                                                             |  |
| 17 INFORMANT                                                                                                                                                                                                                                                                                                                                                                                       |  | ADDRESS                                                                                                                                    |  | 17a. DATE OF OPERATION                                                                                                                                  |  |
| Mrs. Mary L. Hall                                                                                                                                                                                                                                                                                                                                                                                  |  | Silver Spring, Maryland                                                                                                                    |  | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                        |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>                                                                                                                                                                                                                                                |  | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left Cerebral Vascular Accident</u>                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |  |
| 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost                                                                                                                                                                                                                                                                                                 |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Adult Onset Diabetes, Chronic Obstructive Lung Disease</u>                                                                                                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |
| 22a. I certify that <u>xx</u> (this hospital) attended the deceased from <u>June 10</u> , 19 <u>79</u> , to <u>June 27</u> , 19 <u>79</u> , that <u>xx</u> (we) lost saw the deceased alive on <u>June 27</u> , 19 <u>79</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>xx</u> (we) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                         |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED                                                                                                                                        |  |
| <u>Beth Hewitt md</u>                                                                                                                                                                                                                                                                                                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 6-27-79                                                                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS                                                                                                                               |  |                                                                                                                                                         |  |
| Beth Hewitt, M.D.                                                                                                                                                                                                                                                                                                                                                                                  |  | c/o Maryland General Hospital                                                                                                              |  |                                                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                             |  | June 29, 1979                                                                                                                              |  | Glen Haven Cemetery                                                                                                                                     |  |
| 23d. LOCATION CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                         |  | 23e. DATE REC'D. BY REGISTRAR                                                                                                              |  | 23f. REGISTRAR'S SIGNATURE                                                                                                                              |  |
| Glen Burnie                                                                                                                                                                                                                                                                                                                                                                                        |  | JUN 29 1979                                                                                                                                |  | Anne Arundel, MD.                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  |
| Ruck Towson Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                     |  | Towson, Md. 21204                                                                                                                          |  | JUN 29 1979                                                                                                                                             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                 |  | 7 9 1 4 4 6 4<br>REG. NO.                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                    |  | FIRST MIDDLE LAST<br>FREDERICK A. MORELAND                                                                                        |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>06 19 79                                                    |  | 2b. HOUR<br>1:45 A M                                                                                                                  |  |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br>White                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>04 06 97                                                                                                                 |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.                                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, (City) MD.                                    |  |                                                                                                                                       |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auto Parts                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                                                   |  | 13b. COUNTY<br>A.A.                                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>212 AUDREY AVENUE                                                                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>THOMAS MORELAND                                                                                                                                                                                                                                                                                              |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH JONES                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>217 12 7206                                                                                           |  | 17 INFORMANT ADDRESS<br>Ruth Tully 5120 Arbutus Ave. 21227                                                                                                  |  |                                                                                                 |  |                                                                                                                                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac failure</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE ANTERIOR AND SEPTAL MYOCARDIAL</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SEVERE CORONARY ARTERIO SCLEROSIS</u><br>IN FARCTS |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                  |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>06-09, 19 79</u> , to <u>06-19, 19 79</u> , that (I) (we) last saw the deceased alive on <u>06-19, 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><i>M. Fleischman</i>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br>06/19/79                                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. Fleischman                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 22e. ADDRESS<br>South Balto. General Hosp                                                                                                                   |  |                                                                                                 |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>6/22/79                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn A.A. Md.                                 |  |                                                                                                                                       |  |
| 24 FUNERAL DIRECTOR NAME<br>George J. Gonce                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | ADDRESS<br>4001 Ritchie Hwy Balto 21225                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard A. Bandy</i>                                                                                 |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | REG. NO. 14465                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 7a. DATE KNOWN OF DEATH                                                                                                                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth W. Morgan                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR 6 9 1979                                                                                                                                  |  |
| 2. SEX RACE 4. DATE OF BIRTH 5. AGE (IN YEARS) 6. IF UNDER 1 YR. 7. IF UNDER 24 HRS. Female White Jan 30 1891 88 YRS. MONTH DAY YEAR MONTHS DAYS HOURS MIN                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 7c. DATE PRONOUNCED DEAD 6 10 1979                                                                                                                       |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH Baltimore City                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4104 West Bay Court                              |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Binder                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  |
| 13a. STATE Md.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 13b. COUNTY                                                                                                                                              |  |
| 13c. CITY OR TOWN Balto.                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |
| 13e. STREET ADDRESS 4104 West Bay Ct.                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry J. Ostendorf                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E.                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 212 01 5309                                                                                                                     |  |
| 17. INFORMANT ADDRESS Balto 21225 Edmund N. Dalton 3823 St. Victor St                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4392 }<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) }<br>(c) }                                                                                                                                  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                              |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| ACTUAL SIGNATURE Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY) Deputy Chief                                                                                                                             |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | DATE SIGNED 6/11/79                                                                                                                                      |  |
| ADDRESS 111 Penn St. Balto., MD.                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 23b. DATE 6/13/79                                                                                                                                        |  |
| 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 23d. LOCATION Baltimore                                                                                                                                  |  |
| 23e. COUNTY Md.                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 23f. STATE                                                                                                                                               |  |
| 24. FUNERAL DIRECTOR NAME George J. Gonce                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | ADDRESS Balto 21225 4001 Ritchie Hgwy                                                                                                                    |  |
| 25a. DATE REC'D. BY REGISTRAR JUN 14 1979                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14466

FOR  
1- REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--------------------------------------|---------------------|-----|-------------------------------------------------------------------------------------|--------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                              |         | FIRST                                                                                                      |  | MIDDLE                                                                                                                                                      |  | LAST                                                                                               |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                                                       |                                      | MONTH               | DAY | YEAR                                                                                | 2b. HOUR     |
| Patricia D. Morgan                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                    |  | 6                                                                                               |                                      | 16                  | 19  | 79                                                                                  | M            |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                         |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.                                                                                                                     |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                           |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                                                  |                                      | MONTH               | DAY | YEAR                                                                                | 2d. HOUR     |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Black   | 7 22 59                                                                                                    |  | 19                                                                                                                                                          |  |                                                                                                    |  | 6                                                                                               |                                      | 17                  | 19  | 79                                                                                  | 10:30<br>a M |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                     |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                               |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         | USA                                                                                                        |  |                                                                                                                                                             |  | Baltimore City, MD.                                                                                |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                   |  |                                                                                                 | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                     |     |                                                                                     |              |
| Baltimore City                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 2125 Dennison Street                                                                                       |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                            |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET ADDRESS |     |                                                                                     |              |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                            |  |                                                                                                                                                             |  | Balto.                                                                                             |  |                                                                                                 |                                      | 815 Webb Ct.        |     |                                                                                     |              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                            |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                      |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| Ivan Morgan                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  |                                                                                                                                                             |  | Mary J. Carter                                                                                     |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                            |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT                                                                                      |  |                                                                                                 |                                      | ADDRESS             |     |                                                                                     |              |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  |                                                                                                                                                             |  | Mary J. Edwards                                                                                    |  |                                                                                                 |                                      | 815 Webb Ct.        |     |                                                                                     |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds of back (Handgun)</u><br>9650<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                  |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                 |                                      |                     |     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                              |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                    |  |                                                                                                 |                                      |                     |     | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                             |         |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 6 16 19 79                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>shot by assailant |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>house                                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2125 Dennison St. Balto. MD                   |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| ACTUAL<br>SIGNATURE <u>Virginia L. Dolan</u>                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                            |  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                                           |  |                                                                                                    |  | DATE<br>SIGNED 6/18/79                                                                          |                                      |                     |     |                                                                                     |              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  | ADDRESS                                                                                                                                                     |  |                                                                                                    |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                            |  | 111 Penn St. Balto., MD.                                                                                                                                    |  |                                                                                                    |  |                                                                                                 |                                      |                     |     |                                                                                     |              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                     |         | 23b. DATE                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                      |                     |     |                                                                                     |              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         | 6/21/79                                                                                                    |  | Baltimore Cem.                                                                                                                                              |  |                                                                                                    |  | Baltimore, Md.                                                                                  |                                      |                     |     |                                                                                     |              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  |                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE                                                                      |                                      |                     |     |                                                                                     |              |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                            |  | JUN 19 1979                                                                                                                                                 |  |                                                                                                    |  | <u>Pitney Kelsoy</u>                                                                            |                                      |                     |     |                                                                                     |              |



W. J. Wells Co.

Oct 10

Nov 10

Dec 10

Jan 11

W. J. Wells Co.

Feb 11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 6 7

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                              |        |                                                                                                                                                            |                                                                           |                                                                                                 |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                          |  | FIRST<br>OSCAR                                                                                                               | MIDDLE | LAST<br>MORLOCK                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 30 79                            |                                                                                                 | 2b. HOUR<br>9:15 P.<br>M.                                                                                                  |                                              |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE<br>White                                                                                                              |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB. 22, 1897                                                                                                        |                                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82                                                            |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant                                                                             |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                            |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                  |        | 13c. CITY OR TOWN<br>Baltimore                                                                                                                             |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>6112 Pimlico Rd.      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Oscar H. Morlock                                                                                                                                                                                                                                                                                                                    |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Doris Starr                                                                  |        |                                                                                                                                                            |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>WW I                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>146-07-8320                                                       |        | 17. INFORMANT<br>ADDRESS<br>Mrs. Bertha L. Morlock Same                                                                                                    |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u><br><u>1560</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ADENOCARCINOMA OF GALL BLADDER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____ |  |                                                                                                                              |        |                                                                                                                                                            |                                                                           |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                            |  |                                                                                                                              |        |                                                                                                                                                            |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |        |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                       |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 28</u> 19 <u>79</u> to <u>JUNE 30</u> 19 <u>79</u> , that (I) <u>we</u> lost saw the deceased <u>live or above (s) we</u> (did not) view the body after death.                                                                                                                                    |  |                                                                                                                              |        |                                                                                                                                                            |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>Beta Kuppensmeyer</u>                                                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                                                                       |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |                                                                           |                                                                                                 | 22c. DATE SIGNED<br><u>6/30/79</u>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Beta Kuppensmeyer</u>                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br><u>CHURCH HOSP</u>                                                                                           |        |                                                                                                                                                            |                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Transit-Burial                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>July 4, 1979                                                                                                    |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Assinins Cemetery                                                                                                    |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baraga, Baraga Co., Mich.                         |                                                                                                                            |                                              |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc.                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br>6500 York Rd.<br>Balto., Md.                                                                                      |        | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                                                                                |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                |                                                                                                                            |                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1973 JUL 2 10 00 AM '68

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 1 4 4 6 8  
REG NO.

|                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                |                                                                                                                                                      |  |                                                                                  |                                                                                                                            |                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clarence Levi Morris</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 23 79</b>                  |                                                                                                                                                            |                                                                | 2b HOUR<br><b>11:45p</b>                                                                                                                             |  |                                                                                  |                                                                                                                            |                                                  |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE<br><b>Blac k</b>                                                                                                                  |                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 12 1898</b>                                                                                                     |                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                                                                                     |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>                                 |                                                                                                                            | 7 IF UNDER 24 HRS.<br>HOURS MIN.<br><b>00 00</b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                         |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                     |  |                                                                                  |                                                                                                                            |                                                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>512 Lynnhurst Street</b> |                                                                        |                                                                                                                                                            |                                                                | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>                                                                   |  |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Public School</b>                                                                  |                                                  |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                              |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                      |                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |  | 13e STREET ADDRESS<br><b>512 Lynnhurst Street</b>                                |                                                                                                                            |                                                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Morris</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |                                                                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Davis</b>                                                                                           |                                                                |                                                                                                                                                      |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |                                                                                                                            |                                                  |  |
| 16b SOCIAL SECURITY NO.<br><b>213-18-3345</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |                                                                        | 17 INFORMANT<br><b>Mrs. Mable H. Morris</b>                                                                                                                |                                                                |                                                                                                                                                      |  | 18 ADDRESS<br><b>512 Lynnhurst St.</b>                                           |                                                                                                                            |                                                  |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Cardiopulmonary Arrest</b><br><b>1552</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b): <b>HEPATIC CARCINOMA/CIRRHOSIS</b><br>years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                |                                                                                                                                                      |  |                                                                                  |                                                                                                                            |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                |                                                                                                                                                      |  |                                                                                  |                                                                                                                            |                                                  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  |  |                                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                  |                                                                                                                            |                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                      |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                  |                                                                                                                            |                                                  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>5/16</b> , 19 <b>79</b> , to <b>6/6</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                |                                                                                                                                                      |  |                                                                                  |                                                                                                                            |                                                  |  |
| 22b. SIGNATURE<br><b>Alien Acioffo</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                  | 22c. DATE SIGNED<br><b>6/26/79</b>                                                                                         |                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALIEN ACIOFFO</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                | 22e. ADDRESS<br><b>601 N BROADWAY, BALTO MD</b>                                                                                                      |  |                                                                                  |                                                                                                                            |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          | 23b. DATE<br><b>June 27, 79</b>                                        |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b> |                                                                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County Maryland</b>   |                                                                                                                            |                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Herbert E. Nutter 3035 W. North Ave.</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |                                                                        |                                                                                                                                                            |                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                  |  |                                                                                  | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>                                                                      |                                                  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

8 0 4 1 5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------|--|----------------------------------------------|
| 1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                          |  | FOR                                                                                                    |  | 9 1 4 4 6 9                                                                                                                                             |  | REG. NO.                                                            |  |                                                               |  |                                              |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | FIRST MIDDLE LAST                                                                                                                                       |  | 2a DATE OF DEATH                                                    |  | MONTH DAY YEAR                                                |  | 2b HOUR                                      |
| Helem L. MORRIS                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                         |  | 06-1-79                                                             |  | 9.25 A                                                        |  | M                                            |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                        |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH                                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR                                               |  | IF UNDER 24 HRS                              |
| Female                                                                                                                                                                                                                                                                                                                                                                       |  | White                                                                                                  |  | 05 09 30                                                                                                                                                |  | 49 YRS.                                                             |  | MONTHS DAYS                                                   |  | HOURS MIN.                                   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                     |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                                               |  |                                              |
| Ind.                                                                                                                                                                                                                                                                                                                                                                         |  | U.S.A.                                                                                                 |  |                                                                                                                                                         |  | Baltimore city MD.                                                  |  |                                                               |  |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                         |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b KIND OF BUSINESS OR INDUSTRY                              |  |                                              |
| Balto.                                                                                                                                                                                                                                                                                                                                                                       |  | South Balto. General                                                                                   |  |                                                                                                                                                         |  | Nurse                                                               |  | Nursing Co.                                                   |  |                                              |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                  |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                                                        |  | 13d INSIDE CITY LIMITS?                                             |  | 13e STREET ADDRESS                                            |  |                                              |
| MD                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | Balto                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1142 Sargeant St 4223                                         |  |                                              |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                             |  | 15 MOTHER'S MAIDEN NAME                                                                                |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b SOCIAL SECURITY NO.                                             |  | 17 INFORMANT ADDRESS                                          |  |                                              |
| EARL                                                                                                                                                                                                                                                                                                                                                                         |  | Ruth                                                                                                   |  | No                                                                                                                                                      |  | 218-266525                                                          |  | Herbert Morris - 1142 Sargeant St. 21223                      |  |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction, left ventricle</u>                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  |                                                                                                                                                         |  | 20a AUTOPSY?                                                        |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |  | 21b TIME OF INJURY                                                                                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                                               |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                              |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                              |  | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
| 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                          |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION                                                                                                                                            |  |                                                                     |  |                                                               |  |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                        |  |                                                                     |  |                                                               |  |                                              |
| 22a I certify that (I) (this hospital) attended the deceased from <u>05/29</u> , 19 <u>79</u> , to <u>6</u> <u>1/1</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6</u> <u>1/1</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  |                                                               |  |                                              |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | DEGREE                                                                                                                                                  |  |                                                                     |  | 22c DATE SIGNED                                               |  |                                              |
| <u>M. Fleischman</u>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                     |  | 6/1/79                                                        |  |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 22e ADDRESS                                                                                                                                             |  |                                                                     |  |                                                               |  |                                              |
| Miguel Fleischman                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | South Balto. General                                                                                                                                    |  |                                                                     |  |                                                               |  |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                     |  | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d LOCATION                                                        |  | 23e COUNTY STATE                                              |  |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                       |  | 6-4-79                                                                                                 |  | Theodore J. Hem. St.                                                                                                                                    |  | Levenson Park                                                       |  | Baltimore                                                     |  |                                              |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                          |  | 24b ADDRESS                                                                                            |  | 25a BY RECEIVED BY                                                                                                                                      |  | 25b RECEIVED BY                                                     |  | 25c SIGNATURE                                                 |  |                                              |
| John J. Brown                                                                                                                                                                                                                                                                                                                                                                |  | 101 N. Hollins St.                                                                                     |  | JUN 4 1979                                                                                                                                              |  |                                                                     |  |                                                               |  |                                              |

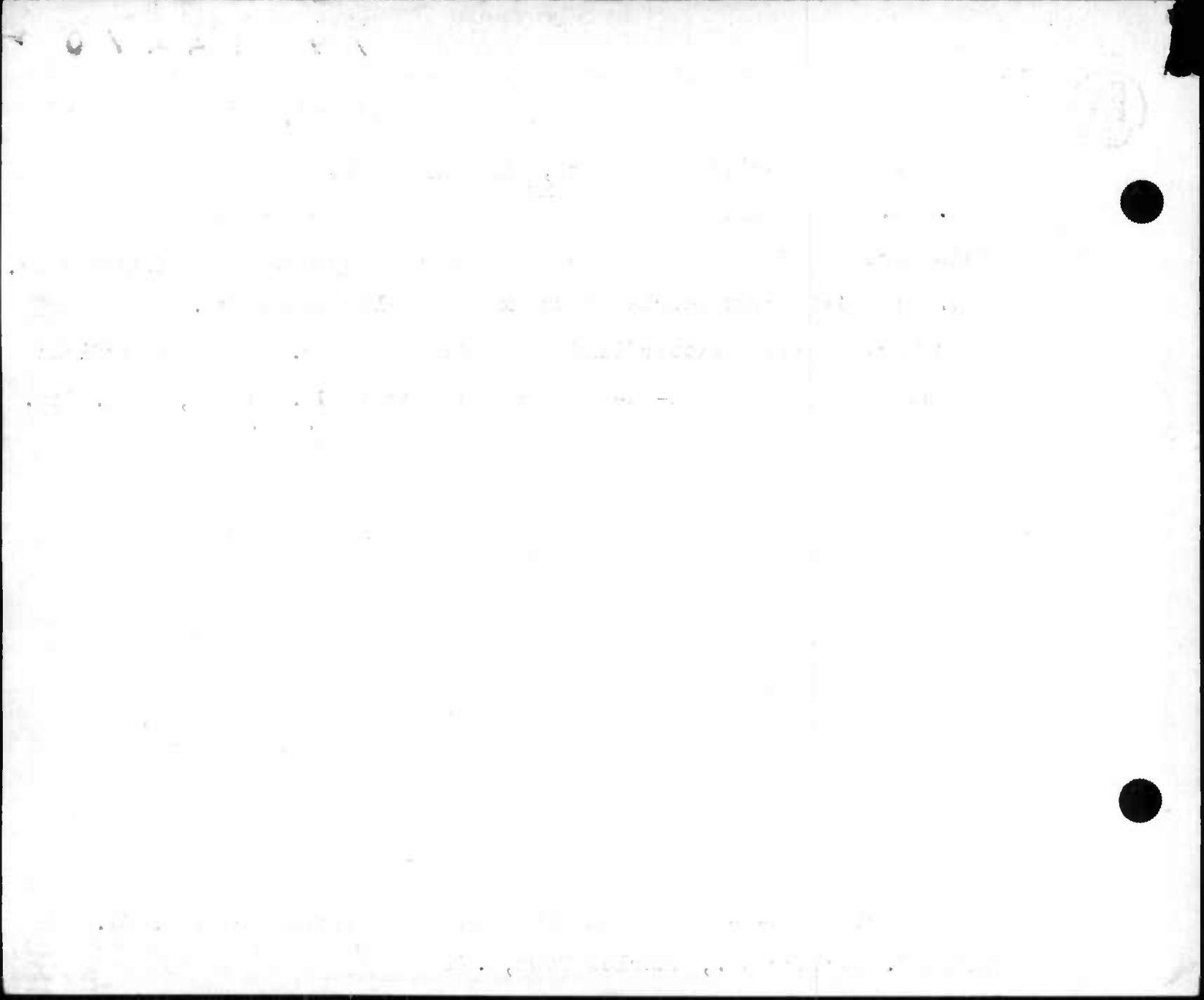




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

MORRIS LEMOINE  
70 91 141 4470  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                   |
| LEMOINE MORRISS                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | JUNE 4, 1979                                                                                                                                             |                                                                     | 1:39 P <sub>M</sub>                                                            |                                   |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                              | 4 RACE                                                                                                    | 5 DATE OF BIRTH                                                                                                                                          | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | IF UNDER 1 YEAR                                                                |                                   |
| female                                                                                                                                                                                                                                                                                                                                                             | white                                                                                                     | Oct, 1 1914                                                                                                                                              | 64 YRS                                                              | IF UNDER 24 HRS                                                                |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                |                                   |
| W. Va.                                                                                                                                                                                                                                                                                                                                                             | USA                                                                                                       |                                                                                                                                                          | BALTIMORE CITY MD.                                                  |                                                                                |                                   |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore                                                                                                                                                                                                                                                                                                                                                          | THE JOHNS HOPKINS HOSPITAL                                                                                |                                                                                                                                                          | Operator                                                            |                                                                                | Telephone Co.                     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                       | 13b. COUNTY                                                                                               | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |                                   |
| W. Va.                                                                                                                                                                                                                                                                                                                                                             | Jefferson                                                                                                 | Charles Town                                                                                                                                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 100 Maple Ave.                                                                 |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME                                                                                  |                                                                                                                                                          | ADDRESS                                                             |                                                                                |                                   |
| Robert Leon Satterfield                                                                                                                                                                                                                                                                                                                                            | Jesse B. Satterfield                                                                                      |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                               | 16b. SOCIAL SECURITY NO.                                                                                  | 17 INFORMANT                                                                                                                                             |                                                                     |                                                                                |                                   |
| no                                                                                                                                                                                                                                                                                                                                                                 | 232-54-3884                                                                                               | Keith Morris Dr. Box 96, Shen. Jct.                                                                                                                      |                                                                     |                                                                                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>2° to metabolic acidosis</i>                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>respiratory &amp; renal failure</i>                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                  |                                   |
| 6-1-79                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | pericardiotomy, fistula                                                                                                                                  |                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                                                                          |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                   |
|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 1:30 P.M. 6 4 1979                                                                                                                                       |                                                                     |                                                                                |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-1-79</i> 19 <i>79</i> , to <i>6-4-79</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6-4-79</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                               |                                   |
| <i>N<sup>m</sup> Plaso</i>                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | M.D.                                                                                                                                                     |                                                                     | <i>6-4-79</i>                                                                  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                                |                                   |
| W <sup>m</sup> PLASO                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | Johns Hopkins Hospital                                                                                                                                   |                                                                     |                                                                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                       | 23b. DATE                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |                                   |
| burial                                                                                                                                                                                                                                                                                                                                                             | 6-6-79                                                                                                    | Edge Hill Cemetery                                                                                                                                       |                                                                     | Charles Town, W. Va.                                                           |                                   |
| 24 FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                                   |
| Melvin T. Strider Co., Charles Town, W. Va.                                                                                                                                                                                                                                                                                                                        |                                                                                                           | JUN 12 1979                                                                                                                                              |                                                                     | <i>John M. Brady</i>                                                           |                                   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14471

|                                                                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BORIS W. MOSS                                                                                                                                                                                                                                                                   |                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6. 7. 79                                |                                                                                      | 2b. HOUR<br>9:50 P.M.                                                                                                      |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                               | 4. RACE<br>WHITE                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 28 1894                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 XXXX YRS                                 |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERN HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL                                          |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                      |                                                                                                                               | 13b. COUNTY<br>BALTIMORE                                                                                                                                    | 13c. CITY OR TOWN<br>PIKESVILLE                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>7 SLADE AVE., APT. 303 #21208                                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISAAC MOSHKEVICH                                                                                                                                                                                                                                                                                  |                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RISIA DAVIDSON                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01-1767                                                        | 17. INFORMANT<br>ADDRESS<br>MR. LEON MOSS 7 SLADE AVE., APT. 303 #21208                                                                                     |                                                                                |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASHD,<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                        |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                    |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 6.7.1979 to 6.7.79, 1979, that (I) (we) last saw the deceased alive on 6.7.1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>K. HANIF                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                | 22c. DATE SIGNED<br>6.7.79                                                           |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. HANIF                                                                                                                                                                                                                                                                                           |                                                                                                                               | 22e. ADDRESS<br>Luthern Hospital                                                                                                                            |                                                                                |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                         | 23b. DATE<br>6-10-79                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH EL MEMORIAL PARK                                                                                                 |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN BALTO. MD                 |                                                                                                                            |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                  |                                                                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                                                                                                                |                                                                                | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                            |                                                                                                                            |

BP

17-1-1



18



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14472

|                                                                                                                                                                                                                                   |                              |                                                                                                                                                                                                      |                                                                                                                                                          |                                                                               |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------|--|-------|--|------|--|------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                               |                              | FIRST                                                                                                                                                                                                |                                                                                                                                                          | MIDDLE                                                                        |                                      | LAST                                                                |  | 2a. DATE KNOWN OF DEATH                                             |  | MONTH                    |  | DAY   |  | YEAR |  | HOUR |  |  |  |
| Gregory D. Murray (Murry)                                                                                                                                                                                                         |                              |                                                                                                                                                                                                      |                                                                                                                                                          |                                                                               |                                      |                                                                     |  | 6                                                                   |  | 23                       |  | 19    |  | 79   |  | M    |  |  |  |
| 3. SEX                                                                                                                                                                                                                            | 4. RACE                      | 5. DATE OF BIRTH                                                                                                                                                                                     |                                                                                                                                                          | 6. AGE (IN YEARS)                                                             |                                      | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                                                    |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR |  |  |  |
| male                                                                                                                                                                                                                              | black                        | 12 27 53                                                                                                                                                                                             |                                                                                                                                                          | 25 YRS.                                                                       |                                      |                                                                     |  |                                                                     |  | 6                        |  | 23    |  | 19   |  | 79   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| Md.                                                                                                                                                                                                                               | USA                          |                                                                                                                                                                                                      |                                                                                                                                                          |                                                                               | Baltimore, City                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                         |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                                             |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| Baltimore                                                                                                                                                                                                                         |                              | University Hospital STU                                                                                                                                                                              |                                                                                                                                                          |                                                                               |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 13a. STATE                                                                                                                                                                                                                        |                              | 13b. COUNTY                                                                                                                                                                                          |                                                                                                                                                          | 13c. CITY OR TOWN                                                             |                                      | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                                 |  |                          |  |       |  |      |  |      |  |  |  |
| Md.                                                                                                                                                                                                                               |                              |                                                                                                                                                                                                      |                                                                                                                                                          | Balto.                                                                        |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2913 Presstman St.                                                  |  |                          |  |       |  |      |  |      |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                 |                              | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |                                                                                                                                                          |                                                                               |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| Harold                                                                                                                                                                                                                            |                              | Juanita                                                                                                                                                                                              |                                                                                                                                                          |                                                                               |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                |                              | 16b. SOCIAL SECURITY NO.                                                                                                                                                                             |                                                                                                                                                          | 17. INFORMANT                                                                 |                                      | ADDRESS                                                             |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| No                                                                                                                                                                                                                                |                              | 217-64-5210                                                                                                                                                                                          |                                                                                                                                                          | Juanita Murray                                                                |                                      | 2913 Presstman St.                                                  |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                         |                              | PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                          |                                                                                                                                                          | Gunshot wound of head                                                         |                                      | (22 caliber rifle)                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                          |  |       |  |      |  |      |  |  |  |
| 9552                                                                                                                                                                                                                              |                              | IMMEDIATE CAUSE (a)                                                                                                                                                                                  |                                                                                                                                                          | DUE TO, OR AS A CONSEQUENCE OF                                                |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                     |                              | (b)                                                                                                                                                                                                  |                                                                                                                                                          | DUE TO, OR AS A CONSEQUENCE OF                                                |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
|                                                                                                                                                                                                                                   |                              | (c)                                                                                                                                                                                                  |                                                                                                                                                          |                                                                               |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                               |                              |                                                                                                                                                                                                      |                                                                                                                                                          |                                                                               |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                            |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |                                                                                                                                                          | 20. AUTOPEX?                                                                  |                                      | (Ho)                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |       |  |      |  |      |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                    |                              | 21b. TIME OF INJURY                                                                                                                                                                                  |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
|                                                                                                                                                                                                                                   |                              | 7:36 P.M. 6/23 19 79                                                                                                                                                                                 |                                                                                                                                                          | shot self                                                                     |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                         |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |                                                                                                                                                          | 21f. LOCATION                                                                 |                                      | CITY OR TOWN                                                        |  | COUNTY                                                              |  | STATE                    |  |       |  |      |  |      |  |  |  |
|                                                                                                                                                                                                                                   |                              | home                                                                                                                                                                                                 |                                                                                                                                                          | 2913 Presstman Street, Baltimore city                                         |                                      |                                                                     |  |                                                                     |  | MD                       |  |       |  |      |  |      |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: |                              | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                                                                          | TITLE (SPECIFY)                                                               |                                      | MEDICAL EXAMINER                                                    |  | DATE SIGNED                                                         |  | 6/24/79                  |  |       |  |      |  |      |  |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                  |                              | Hormez R. Guard, M.D.                                                                                                                                                                                |                                                                                                                                                          | ADDRESS                                                                       |                                      | 111 Penn Street, Baltimore, MD                                      |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 23a. CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                 |                              | 23b. DATE                                                                                                                                                                                            |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                      | 23d. LOCATION                                                       |  | CITY OR TOWN                                                        |  | COUNTY                   |  | STATE |  |      |  |      |  |  |  |
| Cremation                                                                                                                                                                                                                         |                              | 6/29/79                                                                                                                                                                                              |                                                                                                                                                          | Westview Mem. Pk.                                                             |                                      | Catonsville, Md.                                                    |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                              |                              | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |                                                                                                                                                          | 25b. REGISTRAR'S SIGNATURE                                                    |                                      |                                                                     |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |
| Wm C March F/H                                                                                                                                                                                                                    |                              | 1101 E. North Ave.                                                                                                                                                                                   |                                                                                                                                                          | JUN 25 1979                                                                   |                                      | H. J. McCreedy                                                      |  |                                                                     |  |                          |  |       |  |      |  |      |  |  |  |

2

1411



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 7 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                            |                                                                                             |                                                                                     |                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Ernest A. muse</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br><b>6/21/79</b>                                           |                                                                                     | 2b HOUR<br><b>9:05 AM</b>                                                                                                 |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br><b>BLACK</b>                                                                                                               | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-29-41</b>                                                                                                        | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>38</b> YRS                                           |                                                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                     | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                               |                                                                                     |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                                                                                                                  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>S. L. Deaton M.C.</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                             |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MD</b> 13b COUNTY <b>BALTO.</b> 13c CITY OR TOWN <b>BALTO.</b>                                                                                                                                                                                                                                 |                                                                                                                                      |                                                                                                                                                            | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |                                                                                                                           |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Allen Muse</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Blackwell</b>                       |                                                                                     |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 16b SOCIAL SECURITY NO.<br><b>213-36-2843</b>                                                                                                              |                                                                                             | 17 INFORMANT ADDRESS<br><b>Mary Muse 3935 Greenmount Ave.</b>                       |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Oropharyngeal Carcinoma</b><br><b>1469</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>TERMINAL Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                      |                                                                                                                                                            |                                                                                             |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b><br><b>1 year</b>                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                         |                                                                                                                                      |                                                                                                                                                            |                                                                                             |                                                                                     |                                                                                                                           |
| 19a DATE OF OPERATION<br><b>Dec 1978</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Mouth</b>                                                                               |                                                                                             | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                    |                                                                                                                                      | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                              |                                                                                                                                      | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                             | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from <b>May 24</b> 19 <b>79</b> to <b>June 21</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 20</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                          |                                                                                                                                      |                                                                                                                                                            |                                                                                             |                                                                                     |                                                                                                                           |
| 22b SIGNATURE<br><b>Paul Schufeldt MD</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      |                                                                                                                                                            |                                                                                             | 22c DATE SIGNED<br><b>6/23/79</b>                                                   |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Schufeldt MD</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                            |                                                                                             | 22e ADDRESS<br><b>1406 Chain Highway Glen Burnie</b>                                |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 23b DATE<br><b>6/25/79</b>                                                                                                                                 |                                                                                             | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                        |                                                                                                                           |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 23e DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                         |                                                                                             |                                                                                     |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                       |                                                                                             | 24b REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                 |                                                                                                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 7 8 9 10 11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 4 7 4

|                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         |                                                                                                                                                      |                                                                         |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MAURICE MYERBURG</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 30 79</b>                  |                                                                                                                                                             |                                                         | 2b. HOUR<br><b>7 30 PM</b>                                                                                                                           |                                                                         |                                                                                                                            |  |
| 3. SEX<br><b>M ALE</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>W HITE</b>                                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 1 892</b>                                                                                                       |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>                                                                                                         |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                             |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                    |                                                                         |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Levin Dale Geriatric Ctr. &amp; Hosp.</b> |                                                                        |                                                                                                                                                             |                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUYER</b>                                                                     |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>                                                                    |  |
| 13a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                           |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |                                                                         | 13e. STREET ADDRESS<br><b>WEST #2125 3702 Stratmore Ave.</b>                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL MYERBURG</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                           |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                             |                                                         |                                                                                                                                                      |                                                                         |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-10-4958</b>                                                                             |                                                                        | 17. DR. ROBERT J. MYERBURG 6180 S.W. 90th ST.<br><b>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</b>                        |                                                         |                                                                                                                                                      |                                                                         |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOTENSIVE CRISIS</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>DILATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POSSIBLE SEPTICEMIA</b> |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         |                                                                                                                                                      |                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b>                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>CVA, FREQUENT URINARY TRACT INFECTIONS</b>                                                                                                                                                                                                                 |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         |                                                                                                                                                      |                                                                         |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |  |                                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                         |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                         |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> 19 <b>74</b> to <b>6/30</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/30</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.                                            |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         |                                                                                                                                                      |                                                                         |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                         | 22c. DATE SIGNED<br><b>6/30/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B-ZAW-WIN</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         | 22e. ADDRESS<br><b>LEVINDALE GERIATRIC CENTRE</b>                                                                                                    |                                                                         |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                           | 23b. DATE<br><b>JULY 2, 1979</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>AITZ CHAIM</b> |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROUS, INC. 6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                   |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ALFA I



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

7 9 1 4 4 7 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                                                    |                                                                                                                                                             |                                                                                |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN Stetser Myers</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-30-79</b>                                                                                                       |                                                                                | 2b. HOUR<br><b>1:15</b> <b>(A.M.)</b>                                                                                      |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 24 21</b>                                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                                                                                           | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW Jersey</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                |                                                                                                                            |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. Navy</b>                                                                                                |                                                                                                                                                             |                                                                                |                                                                                                                            |
| 11. KIND OF BUSINESS OR INDUSTRY<br><b>Military</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>A.A. Co.</b> 13c. CITY OR TOWN <b>Baltimore</b> |                                                                                                                                                             |                                                                                |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lester Myers</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel Green</b>                                                                                                                |                                                                                                                                                             |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                         |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1938-1957</b>                                                                                                        |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Gloria A. Fendt Same Address</b>                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST PERS. 2° MI</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ASCENDING COLIC</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>METASTATIC CARCINOMA LUNG.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC OBSTRUCTIVE PULM. DIS.</b> |                         |                                                                                                                                                                                    |                                                                                                                                                             |                                                                                |                                                                                                                            |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                                                    |                                                                                                                                                             |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                   |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                             |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6-30-1979</b> to <b>6-30-1979</b> , that (1) (we) lost<br>saw the deceased alive on <b>6-30-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death.                                                                                                                                    |                         |                                                                                                                                                                                    |                                                                                                                                                             |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><b>Abdul Samad Khan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |                                                                                                                                                             | 22c. DATE SIGNED<br><b>6-30-79</b>                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ABDUL SAMAD KHAN</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 22e. ADDRESS<br><b>SOUTH BALTIMORE GEN. HOSPITAL</b>                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 23b. DATE<br><b>7/3/79</b>                                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem Pk</b>                                                                                                |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Balto Md 21228</b>                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hwy, Balto</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                                                 |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |                                                                                                                            |

 BP  
 DHMH-16 20M  
 (VRA 15, 4) 7/78

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

212A 4 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at 1-800-338-2222.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 4 7 6

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                               |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN SANDERS NASH</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>22</b> YEAR <b>79</b>                                |                                                                                                                               | 2b. HOUR<br><b>11:45</b> <sup>P</sup>           |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>Black</b>                                                                                                                                | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>26</b>                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS                                                |                                                                                                                               | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE, CITY</b> MD                        |                                                                                                                               |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, 3900 LOCH RAVEN BLVD., 21218</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY               |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13b. COUNTY                                                                                                                                            | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |                                                 |
| 14. FATHER'S NAME<br>FIRST <b>LINWOOD</b> MIDDLE <b></b> LAST <b>NASH</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LOUISE</b> MIDDLE <b></b> LAST <b>GROSS</b>                                                                            |                                                                                                 |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW 2</b>                                                                                    | 17. INFORMANT ADDRESS<br><b>VAMC CLINICAL RECORDS BALTO., MD. 21218</b>                                                                                     |                                                                                                 |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>79991</b> IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                                                                                                                                                         |                                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                       |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b></b> P.M. <b>19</b>                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                 |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                 | 21f. LOCATION<br>STREET <b>VAMC, 3900 LOCH RAVEN BLVD., BALTO, MD.</b> CITY OR TOWN <b>BALTO</b> COUNTY <b>MD</b> STATE <b>MD</b>                           |                                                                                                 |                                                                                                                               |                                                 |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6-5</b> , 19 <b>79</b> , to <b>6-22</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>6-22</b> , 19 <b>79</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <b>not</b> view the body after death. |                                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br><b>Robert A. Goralster MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED                                                                                                              |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Goralster</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                        | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>                                                                                              |                                                                                                 |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. DATE<br><b>6/27/79</b>                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>                                                                                                 |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b>                                                |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Lillian McBrady</b>                                                                          |                                                 |

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624:11 51 12

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*Journal of Management Education* 26(7)

DATE: 11/11/74 TIME: 0900, 0915

104 05114 11115 11116 11117 11118 11119 11120 11121 11122 11123 11124 11125 11126 11127 11128 11129 11130 11131 11132 11133 11134 11135 11136 11137 11138 11139 11140 11141 11142 11143 11144 11145 11146 11147 11148 11149 11150 11151 11152 11153 11154 11155 11156 11157 11158 11159 11160 11161 11162 11163 11164 11165 11166 11167 11168 11169 11170 11171 11172 11173 11174 11175 11176 11177 11178 11179 11180 11181 11182 11183 11184 11185 11186 11187 11188 11189 11190 11191 11192 11193 11194 11195 11196 11197 11198 11199 11200 11201 11202 11203 11204 11205 11206 11207 11208 11209 11210 11211 11212 11213 11214 11215 11216 11217 11218 11219 11220 11221 11222 11223 11224 11225 11226 11227 11228 11229 11230 11231 11232 11233 11234 11235 11236 11237 11238 11239 11240 11241 11242 11243 11244 11245 11246 11247 11248 11249 11250 11251 11252 11253 11254 11255 11256 11257 11258 11259 11260 11261 11262 11263 11264 11265 11266 11267 11268 11269 11270 11271 11272 11273 11274 11275 11276 11277 11278 11279 11280 11281 11282 11283 11284 11285 11286 11287 11288 11289 11290 11291 11292 11293 11294 11295 11296 11297 11298 11299 11300 11301 11302 11303 11304 11305 11306 11307 11308 11309 11310 11311 11312 11313 11314 11315 11316 11317 11318 11319 11320 11321 11322 11323 11324 11325 11326 11327 11328 11329 11330 11331 11332 11333 11334 11335 11336 11337 11338 11339 11340 11341 11342 11343 11344 11345 11346 11347 11348 11349 11350 11351 11352 11353 11354 11355 11356 11357 11358 11359 11360 11361 11362 11363 11364 11365 11366 11367 11368 11369 11370 11371 11372 11373 11374 11375 11376 11377 11378 11379 11380 11381 11382 11383 11384 11385 11386 11387 11388 11389 11390 11391 11392 11393 11394 11395 11396 11397 11398 11399 11400 11401 11402 11403 11404 11405 11406 11407 11408 11409 11410 11411 11412 11413 11414 11415 11416 11417 11418 11419 11420 11421 11422 11423 11424 11425 11426 11427 11428 11429 11430 11431 11432 11433 11434 11435 11436 11437 11438 11439 11440 11441 11442 11443 11444 11445 11446 11447 11448 11449 11450 11451 11452 11453 11454 11455 11456 11457 11458 11459 11460 11461 11462 11463 11464 11465 11466 11467 11468 11469 11470 11471 11472 11473 11474 11475 11476 11477 11478 11479 11480 11481 11482 11483 11484 11485 11486 11487 11488 11489 11490 11491 11492 11493 11494 11495 11496 11497 11498 11499 11500 11501 11502 11503 11504 11505 11506 11507 11508 11509 11510 11511 11512 11513 11514 11515 11516 11517 11518 11519 11520 11521 11522 11523 11524 11525 11526 11527 11528 11529 11530 11531 11532 11533 11534 11535 11536 11537 11538 11539 11540 11541 11542 11543 11544 11545 11546 11547 11548 11549 11550 11551 11552 11553 11554 11555 11556 11557 11558 11559 11560 11561 11562 11563 11564 11565 11566 11567 11568 11569 11570 11571 11572 11573 11574 11575 11576 11577 11578 11579 11580 11581 11582 11583 11584 11585 11586 11587 11588 11589 11590 11591 11592 11593 11594 11595 11596 11597 11598 11599 11600 11601 11602 11603 11604 11605 11606 11607 11608 11609 11610 11611 11612 11613 11614 11615 11616 11617 11618 11619 11620 11621 11622 11623 11624 11625 11626 11627 11628 11629 11630 11631 11632 11633 11634 11635 11636 11637 11638 11639 11640 11641 11642 11643 11644 11645 11646 11647 11648 11649 11650 11651 11652 11653 11654 11655 11656 11657 11658 11659 11660 11661 11662 11663 11664 11665 11666 11667 11668 11669 11670 11671 11672 11673 11674 11675 11676 11677 11678 11679 11680 11681 11682 11683 11684 11685 11686 11687 11688 11689 11690 11691 11692 11693 11694 11695 11696 11697 11698 11699 11700 11701 11702 11703 11704 11705 11706 11707 11708 11709 11710 11711 11712 11713 11714 11715 11716 11717 11718 11719 11720 11721 11722 11723 11724 11725 11726 11727 11728 11729 11730 11731 11732 11733 11734 11735 11736 11737 11738 11739 11740 11741 11742 11743 11744 11745 11746 11747 11748 11749 11750 11751 11752 11753 11754 11755 11756 11757 11758 11759 11760 11761 11762 11763 11764 11765 11766 11767 11768 11769 11770 11771 11772 11773 11774 11775 11776 11777 11778 11779 11780 11781 11782 11783 11784 11785 11786 11787 11788 11789 11790 11791 11792 11793 11794 1179

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14477

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        |                                                                                                                                               |                                                           |                                                                                                                                                            |                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT L. NASH</b>                                                                                                                                                                                                                                                                                                                                                                               |                        |                                                                                                                                               | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 8, 1979</b> |                                                                                                                                                            | 2b HOUR<br><b>2:54pm</b>                                                                            |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                      | 4 RACE<br><b>WHITE</b> | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 2 1910</b>                                                                                        |                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS                                                                                                            |                                                                                                     |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WISC.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                        | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                           | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                     |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                        | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                           | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ADMINISTRATOR</b>                                                                    |                                                                                                     |
| 13a STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                        | 13b COUNTY<br><b>BALTO.</b>                                                                                                                   |                                                           | 13c CITY OR TOWN<br><b>TOWSON</b>                                                                                                                          |                                                                                                     |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES E. NASH</b>                                                                                                                                                                                                                                                                                                                                                                           |                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLORENCE SMITH</b>                                                                         |                                                           | 16 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                            |                                                                                                     |
| 17a SOCIAL SECURITY NO.<br><b>281-20-5539A</b>                                                                                                                                                                                                                                                                                                                                                                                            |                        | 17 INFORMANT<br><b>MARY P. NASH</b>                                                                                                           |                                                           | 18 ADDRESS<br><b>SAME</b>                                                                                                                                  |                                                                                                     |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Hypoxia, Hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction, Pulmonary edema</b> |                        |                                                                                                                                               |                                                           |                                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>40 minutes</b><br><b>12 hrs</b><br><b>24 hrs</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Multiple Visceral Cholesterol Emboli; Renal Failure; Obstruction</b>                                                                                                                                                                                                                             |                        |                                                                                                                                               |                                                           |                                                                                                                                                            |                                                                                                     |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                           | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                                                                     |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |                        | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |                                                           | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                     |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |                        | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                           | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                     |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/5</b> 19 <b>79</b> to <b>6/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/8</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                                                                                      |                        |                                                                                                                                               |                                                           |                                                                                                                                                            |                                                                                                     |
| 22b SIGNATURE<br><b>Peter Rock</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                        | DEGREE<br><b>MD</b>                                                                                                                           |                                                           | 22c DATE SIGNED<br><b>6/8/79</b>                                                                                                                           |                                                                                                     |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Rock</b>                                                                                                                                                                                                                                                                                                                                                                                 |                        | 22e ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                  |                                                           |                                                                                                                                                            |                                                                                                     |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                 |                        | 23b DATE<br><b>6-11-79</b>                                                                                                                    |                                                           | 23c NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>                                                                                                 |                                                                                                     |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TIMONIUM BALTO. MD.</b>                                                                                                                                                                                                                                                                                                                                                                   |                        | 24 FUNERAL DIRECTOR<br>NAME<br><b>H. W. JENKINS &amp; SONS CO. BALTO., MD.</b>                                                                |                                                           | 25 DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                                                          |                                                                                                     |
| 26 REGISTRAR'S SIGNATURE<br><b>Peter Rock</b>                                                                                                                                                                                                                                                                                                                                                                                             |                        | 27 REGISTRAR'S SIGNATURE<br><b>Peter Rock</b>                                                                                                 |                                                           |                                                                                                                                                            |                                                                                                     |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

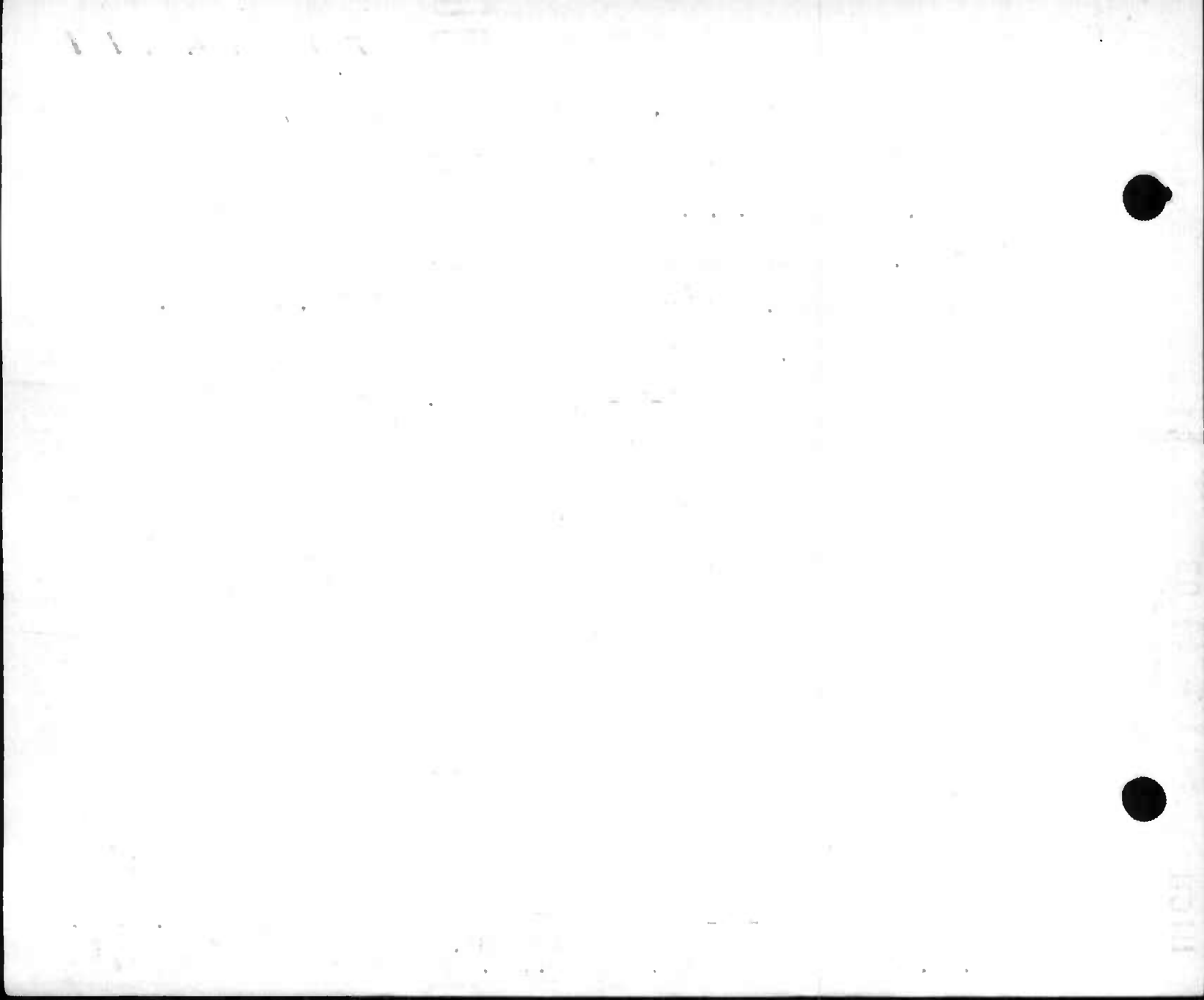
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

182-17-03  
NASH ROBERT  
05 02 10

NICU7

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



BP

DHMH - 16 50M 7/77  
(VR A15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                   |  | REG. NO. 9 1 4 4 7 8                                                                                      |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                            |  | FIRST JAMES                                                                                               |  | MIDDLE I.                                                                                                                                                   |  | LAST NAYLOR                                                         |  | 20. DATE OF DEATH<br>MONTH DAY YEAR |  |
|                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  | JUNE 29, 1979                       |  |
| 3. SEX                                                                                                                                                         |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7b. HOUR                            |  |
| Male                                                                                                                                                           |  | White                                                                                                     |  | MONTH 6 DAY 22 YEAR 16                                                                                                                                      |  | 63 YRS                                                              |  | 1:05P M                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                     |  |
| Windber, Pa                                                                                                                                                    |  | USA                                                                                                       |  |                                                                                                                                                             |  | Baltimore, City                                                     |  | MD.                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore                                                                                                                                                      |  | Church Home & Hospital                                                                                    |  |                                                                                                                                                             |  | checker                                                             |  | Bethel, Steel                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                   |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                 |  |
| Md                                                                                                                                                             |  | Baltimore                                                                                                 |  |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 6912 Brentwood Avenue               |  |
| 14. FATHER'S NAME                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME                                                                                  |  | 16. SOCIAL SECURITY NO.                                                                                                                                     |  | 17. INFORMANT                                                       |  | ADDRESS                             |  |
| FIRST MIDDLE LAST                                                                                                                                              |  | FIRST MIDDLE LAST                                                                                         |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| James F Naylor                                                                                                                                                 |  | Annie Ingrund                                                                                             |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                           |  | 18b. SOCIAL SECURITY NO.                                                                                  |  | 19. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |  |                                     |  |
| no                                                                                                                                                             |  |                                                                                                           |  | Mrs. James Naylor                                                                                                                                           |  | 6912 Brentwood Avenue                                               |  |                                     |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:                                                       |  | CARDIAC ARREST                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| IMMEDIATE CAUSE (a)                                                                                                                                            |  | 410- ACUTE ANTEROLATERAL MYOCARDIAL INFARCTION                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                 |  | (b) acute anterolateral myocardial infarction                                                             |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                 |  | (c) ARTERIOSCLEROTIC HEART DISEASE                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.                                                                 |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                   |  | MINUTES 5 DAYS                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                            |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                     |  |
| 6-26-79                                                                                                                                                        |  | COMPLETE AV BLOCK                                                                                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                     |  |                                     |  |
|                                                                                                                                                                |  | P.M. 19                                                                                                   |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET                                                                                                                                     |  | CITY OR TOWN                                                        |  | COUNTY STATE                        |  |
|                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                     |  |
| 22a. I certify that (If this hospital attended the deceased from above, (If we did) did not) view the body after death.                                        |  | JUNE 29, 1979                                                                                             |  | JUNE 29, 1979                                                                                                                                               |  | JUNE 29, 1979                                                       |  | JUNE 29, 1979                       |  |
| 22b. SIGNATURE                                                                                                                                                 |  | DEGREE                                                                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED                                                    |  |                                     |  |
| George C. Rovetti, M.D.                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  | 6-29-79                                                             |  |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                          |  | 22e. ADDRESS                                                                                              |  | 22f. ADDRESS                                                                                                                                                |  | 22g. ADDRESS                                                        |  |                                     |  |
| George C. Rovetti, M.D.                                                                                                                                        |  | 100 N. BROADWAY, BALTIMORE, MD                                                                            |  | 100 N. BROADWAY, BALTIMORE, MD                                                                                                                              |  | 100 N. BROADWAY, BALTIMORE, MD                                      |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                      |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY STATE                        |  |
| Burial                                                                                                                                                         |  | 7/3/79                                                                                                    |  | Mt. Carmel                                                                                                                                                  |  | Jemers                                                              |  | Cross Roads                         |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                   |  | 24b. ADDRESS                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                     |  |
| Walter Dabrowski                                                                                                                                               |  | 1005 Dundalk Avenue                                                                                       |  | JUL 6 1979                                                                                                                                                  |  | Ruthy McBrady                                                       |  |                                     |  |



|       |           |                        |         |                 |     |       |    |    |    |
|-------|-----------|------------------------|---------|-----------------|-----|-------|----|----|----|
| no    | Baltimore | Charch Home & Hospital | checker | Baltimore, City | USA | White | 10 | 12 | 10 |
| James | Baltimore | Charch Home & Hospital | checker | Baltimore, City | USA | White | 10 | 12 | 10 |
| no    | Baltimore | Charch Home & Hospital | checker | Baltimore, City | USA | White | 10 | 12 | 10 |

*[Faint, illegible handwritten text and signatures across the middle section of the document.]*

|        |        |            |       |             |
|--------|--------|------------|-------|-------------|
| Burial | 7/2/78 | Mc. Carmel | James | Cross Roads |
|--------|--------|------------|-------|-------------|



Page 1 of 1  
 NEIBERLINE, KENNETH  
 180 1698  
 HEL 87  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the death certificate file.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                     |  | 2a. DATE OF DEATH                                                                                      |  | 2b. HOUR                                                                                                                                                 |  | REG. NO.                                                            |  |                                    |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                            |  | 3. SEX                                                                                                 |  | 4 RACE                                                                                                                                                   |  | 5. DATE OF BIRTH                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)    |  |
| Kenneth M. Neiberline SR.                                                                                                                                                                                                                                                                                                  |  | MALE                                                                                                   |  | WHITE                                                                                                                                                    |  | MARCH 25, 1916                                                      |  | 63 YRS                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                   |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City                                                      |  | NEWS PAPER                         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | MD                                 |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                  |  | The Johns Hopkins Hospital                                                                             |  | PRINTER                                                                                                                                                  |  |                                                                     |  |                                    |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                   |  | BALTIMORE                                                                                              |  | TOWSON                                                                                                                                                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 414 BROOK RD. 21204                |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT ADDRESS              |  |
| HARRY                                                                                                                                                                                                                                                                                                                      |  | VIRGINIA RANDALL                                                                                       |  | YES                                                                                                                                                      |  | 215-10-8869                                                         |  | MIRIAM H. NEIBERLINE 414 BROOK RD. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| DO NOT WRITE IN THESE SPACES                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Os/p @ lower lobectomy @ histiocytic lymphoma.</u>                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                    |  |
| 6/14/79                                                                                                                                                                                                                                                                                                                    |  | carcinoma @ lower lobe                                                                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                    |  |
|                                                                                                                                                                                                                                                                                                                            |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                    |  |
|                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from 6/13/79, 19 79, to 6/15/79, 19 79, that (I) (we) last saw the deceased alive on 6/15/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                    |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                             |  | 22c. DATE SIGNED                                                                                       |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                    |  | 22e. ADDRESS                                                        |  |                                    |  |
| HARTZELL V. Schaff                                                                                                                                                                                                                                                                                                         |  | 6/15/79                                                                                                |  | HARTZELL V. Schaff                                                                                                                                       |  | Johns Hopkins Hospital                                              |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                    |  |
| CREMATION                                                                                                                                                                                                                                                                                                                  |  | JUNE 18, 79                                                                                            |  | LOUDON PARK                                                                                                                                              |  | BALTIMORE MD.                                                       |  |                                    |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                  |  | 24b. ADDRESS                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                    |  |
| MITCHELL-WIEDEFELD HOME                                                                                                                                                                                                                                                                                                    |  | 6500 YORK RD.                                                                                          |  | JUN 19 1979                                                                                                                                              |  | History McCreedy                                                    |  |                                    |  |

BP

8 p 44 061

REV. A. J. C. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78

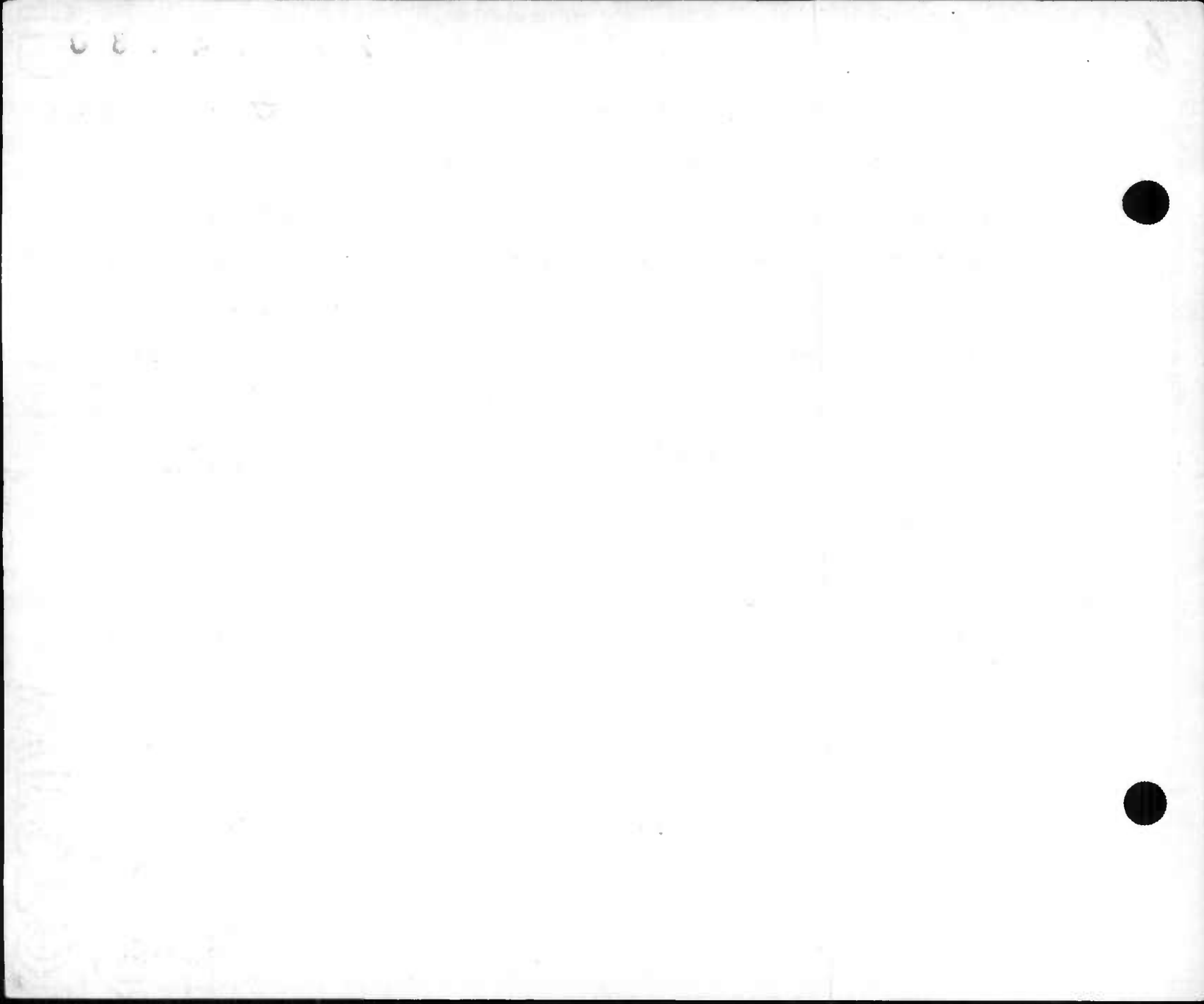
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 8 0

REG NO

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>RAY FRANKLIN NEIKIRK                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 8 79                          |                                                                                                                                                             |                                                        | 2b. HOUR<br>5:45 AM                                                                                                                        |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>WHITE                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 2 17                                                                                                               |                                                        | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                                                                                  |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                              |                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |                                                                        |                                                                                                                                                             |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Checker                                                                |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel                                                                           |                                              |                                         |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      | 13b. COUNTY<br>Baltimore                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>Dundalk                           |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>1947 Frames Road      |                                         |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Levi Henry Neikirk                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annabelle Ferguson     |                                                                                                                                                             |                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II                              |                                                                                                 |                                                                                                                            |                                              | 16b. SOCIAL SECURITY NO.<br>227-12-4054 |  |
| 17 INFORMANT<br>Daisy M. Neikirk                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      | ADDRESS<br>1947 Frames Rd.<br>Balto. MD 21222                          |                                                                                                                                                             |                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF COLON</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                        |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                            |  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-6-79</u> to <u>6-8-79</u> , that (I) (we) last saw the deceased alive on <u>6-8-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 22b. SIGNATURE<br>S. S. Sagar                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      | DEGREE<br>MD                                                           |                                                                                                                                                             |                                                        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br>6/8/79                   |                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. S. SAGAR                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      | 22e. ADDRESS<br>% Good Samaritan Hospital                              |                                                                                                                                                             |                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 23b. DATE<br>6/11/79                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |                                                                                                                            |                                              |                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Avenue, Dundalk, MD 21222                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        | 25. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                                                                                |                                                                                                 | 26. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                   |                                              |                                         |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14481

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                           |                                                                                                                                                             |                                                                |                                                                                      |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH NEISZ</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 4 79</b>           |                                                                                      | 2b. HOUR<br><b>10<sup>00</sup> AM</b>                                                                                      |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>W</b>                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 19 08</b>                                                                                                       |                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 7 YEARS                                                               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NY</b>                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore MD</b>                          |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sonai</b> |                                                                                                                                                             |                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                           |                                                                                                                                                             | 13b. COUNTY<br><b>Balt</b>                                     | 13c. CITY OR TOWN<br><b>Balt</b>                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thersa</b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Miller</b> |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>WU2</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>WU2</b>                                                                                                                      |                                                                | 17. INFORMANT<br>ADDRESS<br><b>MARY B NEISZ 6517 916 more Ave</b>                    |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                           |                                                                                                                                                             |                                                                |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:                                                                                                                                                                                                                                                 |                                                                                                                           |                                                                                                                                                             |                                                                |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                          |                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> to <b>6/4</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/4</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.                                                |                                                                                                                           |                                                                                                                                                             |                                                                |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                           | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                | 22c. DATE SIGNED<br><b>6/4/79</b>                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James J. Piccarini</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                           | 22e. ADDRESS<br><b>Sonai Hospital</b>                                                                                                                       |                                                                |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                      | 23b. DATE<br><b>6-6-79</b>                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>London Park</b>                                                                                                    |                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>                       |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lt. STANBURY 6411 WINDSOR MILL RD</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                                                                                                         |                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |                                                                                                                            |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (F-101).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

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 the necessary funds to carry out its  
 policy of non-interference. This is  
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 interference. This is due to the fact  
 that the government has been unable  
 to secure the necessary funds to carry  
 out its policy of non-interference.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR Items 18b.                                                                                                                                                                                                                                                                                                                     |  | STATE OF MARYLAND                                                                                                                  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                  |  | 7 9 1 4 4 8 2                                                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. STATE REGISTRAR                                                                                                                                                                                                                                                                                                                 |  | 7-16-79                                                                                                                            |  | CERTIFICATE OF DEATH                                                                                                                                     |  | REG. NO.                                                                                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>John H. Nelson</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>6-1-79</b> 2b. HOUR <b>7:20 A.M.</b>                                                                                 |  |                                                                                                                         |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                 |  | 4. RACE <b>Black</b>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>7 7 1912</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS. MONTHS DAYS HOURS MIN.                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.                                                                    |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE <b>MD.</b>                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER H. NELSON</b>                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY NEALE</b>                                                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                              |  |                                                                                                                         |  |
| 16b. SOCIAL SECURITY NO <b>218-09-6477</b>                                                                                                                                                                                                                                                                                         |  | 17. INFORMANT ADDRESS <b>Laura E. Lawson 1334 Ft. Steven Dr.</b>                                                                   |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1874 IMMEDIATE CAUSE (a) Cardiac arrest</b>      |  |                                                                                                                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                      |  | (b) <b>Cancer of the Penis (squamous cell)</b>                                                                                     |  | (c) <b>Squamous cells CA of penis prostate with metastasis to liver.</b>                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>05 24 19 79</b>                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>06-06-79</b> <b>06 06</b> 19 <b>79</b> , that (I) (we) lost <b>06-06-79</b> <b>06 06</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>E.G. COMERO</b>                                                                                                                                                                                                                                                                                                  |  | DEGREE                                                                                                                             |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>060779</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E.G. COMERO</b>                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS <b>204 E. Highfield Rd BALto 21218</b>                                                                                |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                  |  |                                                                                                                         |  |
| 23b. DATE <b>6/11/79</b>                                                                                                                                                                                                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>                                                                                            |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                    |  | ADDRESS <b>1101 E. North Ave.</b>                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>P. J. H. H. H.</b>                                                                        |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **14483**

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Kevin Morgan Nelson</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 3 19 79</b> |  | 2b. HOUR <b>3:20P</b>                                                            |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE <b>White</b>     |  | 5. DATE OF BIRTH <b>June 8 1953</b>                                                                                               |  | 6. AGE (IN YEARS) <b>25</b> YRS.                                                             |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN.                                                                 |  | 2c. DATE PRONOUNCED DEAD <b>6 3 19 79</b>                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                           |  |                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>133 North Bend Rd.</b> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>                                                                        |  |                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                             |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY <b>Balto</b> |  | 13c. CITY OR TOWN <b>Catonsville</b>                                                                                              |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>6217 Collinsway Rd.</b>                                                                                                           |  |                                                                                             |  |                                                                                  |  |
| 14. FATHER'S NAME <b>ROSHARD</b> FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                     |  |                          |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME <b>DRU</b> FIRST MIDDLE LAST <b>HARMONSON</b>                       |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                           |  |                          |  | 16b. SOCIAL SECURITY NO. <b>213-64-4136</b>                                                                                       |  | 17. INFORMANT <b>Richard Nelson</b>                                                          |  |                                                                                                                                                          |  | ADDRESS <b>6217 Collinsway Rd.</b>                                                          |  |                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9550</b> IMMEDIATE CAUSE (a) <b>Gunshot wound to chest (handgun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                     |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>?</b>                                                                                                                                                                                                                                                                                                |  |                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6 3 19 79</b>                                                                     |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>                                                      |  |                                                                                             |  |                                                                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                             |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>                                                           |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>133 North Bend Rd. Balto. MD</b>                                                                       |  |                                                                                             |  |                                                                                  |  |
| 22. I certify that I have examined the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                          |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                          |  | TITLE (SPECIFY) <b>Deputy Chief</b>                                                                                               |  |                                                                                              |  | DATE SIGNED <b>6/4/79</b>                                                                                                                                |  |                                                                                             |  |                                                                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                          |  | ADDRESS <b>111 Penn St. Balto., MD.</b>                                                                                           |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                             |  |                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                          |  | 23b. DATE <b>6-6-79</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>                                 |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. MD.</b>                                   |  |                                                                                  |  |
| 24. FUNERAL DIRECTOR NAME <b>Weber Funeral Home</b> ADDRESS <b>5311 Camondson Ave.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                          |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>                                              |  |                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                  |  |                                                                                  |  |



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES E. NEUWILLER</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 30, 1979</b>                   |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>02:45AM</b>                                                                                                                 |                                                                                                 |                                                                                                                            |                                                        |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Caucasian</b>                                                                                                                    |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 27, 1925</b>                                                                                                  |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>54</b>                                                                            |                                                                                                 | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                           |                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                                                           |                                                                                                 |                                                                                                                            |                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                               |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sheet Metal</b>                                                     |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>E.A. Kasners</b>                                                                   |                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                | 13b. COUNTY<br><b>-</b>                                                       |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                          |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>5135 Wright Avenue 21205</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Neumiller</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Wheatley</b>         |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-01-4390</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Gardenia B. Neuwiller (wife) same as 13</b>     |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5789</b> IMMEDIATE CAUSE (a) <b>Seizure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>90 min</b>                                                              |                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Upper GI Bleed</b>                                                                                                                                                                                                             |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 19a. DATE OF OPERATION<br><b>6/30</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Upper GI Bleed</b>     |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/30</b> , 19 <b>79</b> , to <b>6/30</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 22b. SIGNATURE<br><b>Joshua Farber</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                | DEGREE<br><b>MD</b>                                                           |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6/30/79</b>                                                                                         |                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSHUA FARBER</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                 |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                | 23b. DATE<br><b>7/3/79</b>                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                  |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |                                                                                                                            |                                                        |  |
| 24. FUNERAL DIRECTOR<br><b>Schuminek Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                | 24b. ADDRESS<br><b>331 Brehms Lane Balto. Md. 21213</b>                       |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Littay Melrody</b>                                                                        |                                                        |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(V.R. 115 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14485

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Baby DeJuan Franklin Neville</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                | 2a. DATE KNOWN OF DEATH<br>ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 13 19 79</b>                                                       |                                                                                                 | 2b. HOUR<br><b>M</b>                                                                                                |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>Black</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9-29-76</b>                                                                                                           | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>2</b>                                                | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1217 Ashburton St. (rear)</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Baby</b>                    | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                   |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 13b. COUNTY                                                                                                                                    | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1206 BRADDOCK AVE</b>                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Neville</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Johnson</b>                                                                                      |                                                                                                 |                                                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                     |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>Mr. George Neville 1206 BRADDOCK AVE</b>                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio cerebral trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                               |                                                                                                                                                |                                                                                                                                                             |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                                                                                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 21b. TIME OF INJURY<br>HOURS MIN. MONTH DAY YEAR<br><b>7:45 A.M. 6 13 19 79</b>                                                                             |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>cinder wall fell on subject</b> |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>alley</b>                                                                                 |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1217 Ashburton St. Balto. MD</b>                            |
| 22a. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                     |
| ACTUAL SIGNATURE<br><b>Hormez R. Guard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                                         |                                                                                                 | DATE SIGNED<br><b>6/14/79</b>                                                                                       |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | ADDRESS<br><b>111 Penn St. Balto., MD.</b>                                                                                                                  |                                                                                                 |                                                                                                                     |
| 23a. BURIAL CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br><b>6-17-79</b>                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hickory Grove bpt ch. Chapel Hill N.C.</b>                                                                         |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph L. Russ 2222 W. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                          |                                                                                                 |                                                                                                                     |
| 26. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                     |

MEDICAL CERTIFICATION

BP

14185



Franklin

7-21-10

U.S.A.

Franklin

U.S.A.

U.S.A.

ORIGINAL

17-11-10

17-11-10



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 1 4 4 8 6

1- FOR  
STATE  
REGISTRAR

|                                                                            |                                                                                                                               |                                                                                                                                                         |                                                              |                                                                                                       |                                  |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>BEVERLY</b> <b>NEWKIRK.</b>          |                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR <b>6.9.79.</b>                                                                                                         |                                                              | 2b. HOUR <b>7:00 A.M.</b>                                                                             |                                  |
| 3 SEX <b>F</b>                                                             | 4 RACE <b>B</b>                                                                                                               | 5. DATE OF BIRTH MONTH DAY YEAR <b>08 11 64</b>                                                                                                         |                                                              | 6 AGE (IN YEARS LAST BIRTHDAY) <b>14</b> YRS. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>                        | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                              | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>BALTO. C. TY</b> MD.                                    |                                  |
| 10 CITY OR TOWN OF DEATH <b>BALTO.</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHILDRENS HOSP.</b> |                                                                                                                                                         | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                       | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE <b>md.</b>                                                       |                                                                                                                               | 13b COUNTY                                                                                                                                              | 13c CITY OR TOWN <b>BALTO</b>                                | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>CLARENCE</b> <b>NEWKIRK</b>          |                                                                                                                               | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIE</b> <b>SNEED</b>                                                                                    |                                                              |                                                                                                       |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b> |                                                                                                                               | 16b SOCIAL SECURITY NO. <b>-</b>                                                                                                                        |                                                              | 17 INFORMANT ADDRESS <b>MR. CLARENCE NEWKIRK 2810 GARRISON AVE</b>                                    |                                  |

|                                                                                                                                                 |  |                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> |
| 5241 } DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                 |  |                                                            |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                        |  |                                                            |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 19a DATE OF OPERATION <b>6.9.79.</b>                                                                                                                                                                                                                                                                                                                     |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PROGNATHISM</b>                                                                                          |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6.4</b> 19 <b>79</b> to <b>6.9.</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6.9</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                         |  |
| 22b SIGNATURE <b>R. F. MORGAN</b>                                                                                                                                                                                                                                                                                                                        |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                |  | 22c. DATE SIGNED <b>6 9 79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. F. MORGAN</b>                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS <b>CHILDRENS HOSPITAL. BALTIMORE</b>                                                                                                           |  |                                                                                |  |                                                                                                                         |  |

|                                                                                         |  |                          |  |                                                            |  |                                                           |  |
|-----------------------------------------------------------------------------------------|--|--------------------------|--|------------------------------------------------------------|--|-----------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                 |  | 23b. DATE <b>6-13-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>KING MEMORIAL PK</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. md.</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>Samuel T. Redd</b> ADDRESS <b>5209 YORK Rd. BALTO. md.</b> |  |                          |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>           |  | 25b. REGISTRAR'S SIGNATURE <b>Pitney McBrady</b>          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08451-1-97

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.



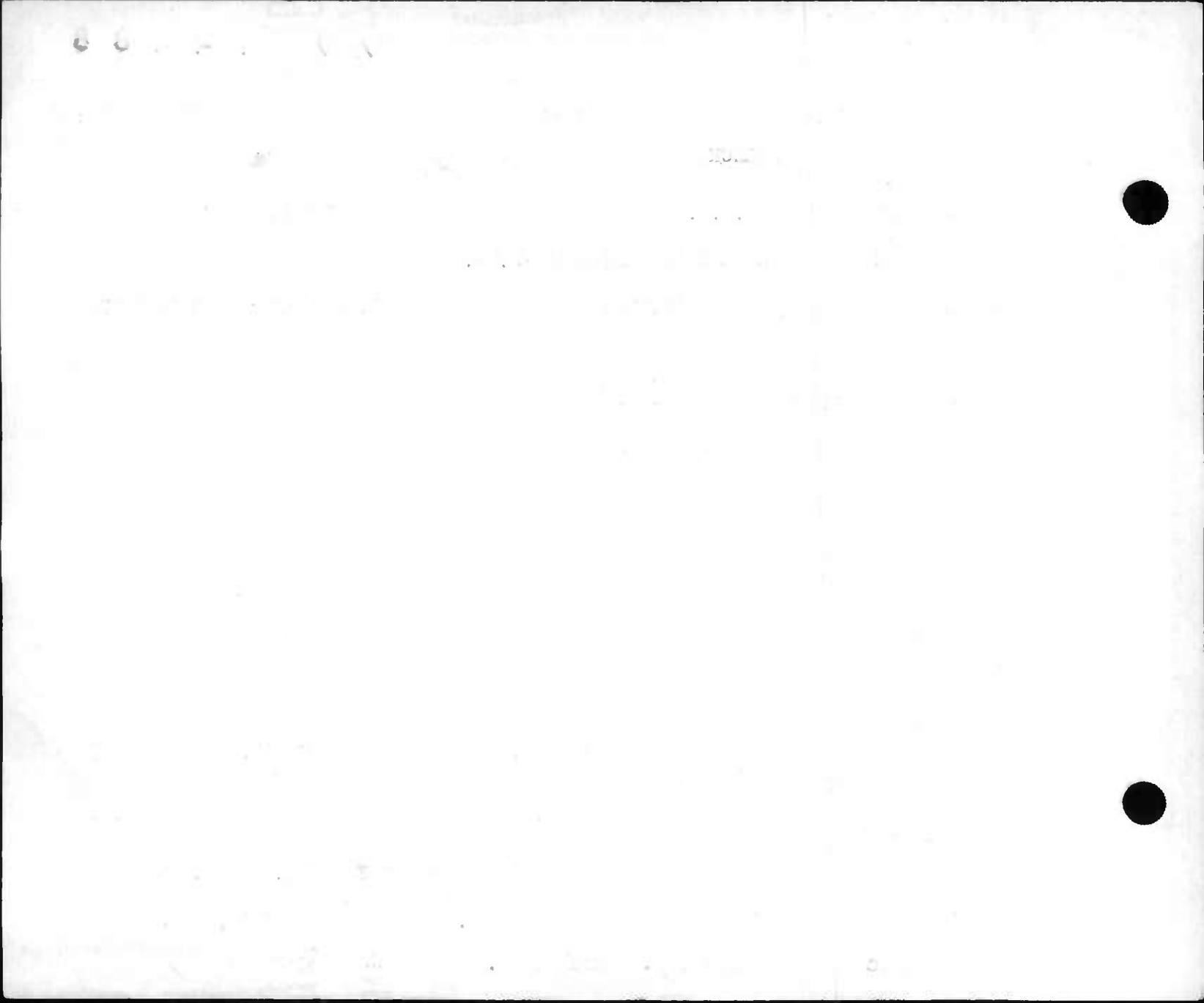
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  | 79 14487                                    |  |                                      |  |          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------|--|--------------------------------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                            |  | 2a. DATE OF DEATH                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  | 2b. HOUR                                    |  |                                      |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                     |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | MONTH                                                               |  | DAY                                         |  | YEAR                                 |  | 2b. HOUR |  |
| Baby Girl NEWTON                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | June 7 1979                                                         |  |                                             |  |                                      |  | 8:30A M  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                  |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                                                  |  | 8. IF UNDER 24 HRS.                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |          |  |
| Female                                                                                                                                                                                                                                                                                                  |  | Black                                                                                                  |  | June 7 1979                                                                                                                                              |  | YRS.                                                                |  | MONTHS                                                              |  | DAYS                                        |  | HOURS                                |  | MIN.     |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                               |  | 7c. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                     |  |                                                                     |  |                                             |  | Baltimore City                       |  | MD       |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                                     |  |                                             |  |                                      |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                               |  | Maryland General Hospital                                                                              |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                                 |  |                                             |  |                                      |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                |  | Baltimore                                                                                              |  |                                                                                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1042 N. Stricker Street                                             |  |                                             |  |                                      |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMATION                                                     |  | ADDRESS                                     |  |                                      |  |          |  |
| Woodrow                                                                                                                                                                                                                                                                                                 |  | Novella                                                                                                |  | NO                                                                                                                                                       |  | NONE                                                                |  | Medical Record                                                      |  | Maryland General Hospital 827 Linden Avenue |  |                                      |  |          |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                      |  | 19. DATE OF OPERATION                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                             |  |                                      |  |          |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                             |  |                                      |  |          |  |
| IMMEDIATE CAUSE (a) <u>Prematurity</u>                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| 7722                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Respiratory Distress</u>                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| (b) <u>Hypoxia</u>                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| (c) <u>Subarachnoid Hemorrhage</u>                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| 21a. INJURY OCCURRED                                                                                                                                                                                                                                                                                    |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  | 21d. LOCATION                                                       |  | 21e. CITY OR TOWN                                                   |  | 21f. COUNTY                                 |  | 21g. STATE                           |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  | STREET                                                              |  |                                                                     |  |                                             |  |                                      |  |          |  |
| 22a. I certify that (1) <del>XXXXXX</del> attended the deceased from June 7, 1979 to June 7, 1979, that (2) we last saw the deceased alive on June 7, 1979, and that in (3) our opinion death occurred on the date and hour and from the causes stated above, (4) we did not view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                          |  | 22c. DATE SIGNED                                                                                       |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                    |  | 22e. ADDRESS                                                        |  |                                                                     |  |                                             |  |                                      |  |          |  |
| Mario Gonzalez                                                                                                                                                                                                                                                                                          |  | 6-7-79                                                                                                 |  | Mario Gonzalez, M.D.                                                                                                                                     |  | c/o Maryland General Hospital                                       |  |                                                                     |  |                                             |  |                                      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                               |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  | 23e. CITY OR TOWN                                                   |  | 23f. COUNTY                                 |  | 23g. STATE                           |  |          |  |
| BURIAL                                                                                                                                                                                                                                                                                                  |  | 6/13/79                                                                                                |  | MT. AUBURN CEMETERY                                                                                                                                      |  | BALTIMORE                                                           |  | BALTIMORE                                                           |  | BALTIMORE                                   |  | MARYLAND                             |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| NAME                                                                                                                                                                                                                                                                                                    |  | ADDRESS                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |                                             |  |                                      |  |          |  |
| LEWIS T. GWYNN                                                                                                                                                                                                                                                                                          |  | 4517 PARK HEIGHTS AVENUE                                                                               |  |                                                                                                                                                          |  | JUN 19 1979                                                         |  | Dorothy M. Brady                                                    |  |                                             |  |                                      |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 7 9 1 4 4 8 8                                                                                                                                                 |  |                                                                                                                        |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | REG. NO.                                                                                                                                                      |  |                                                                                                                        |                                              |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GEORGE NEWTON</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>6 11 79</b>                                                                                                             |  |                                                                                                                        |                                              |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 4 RACE<br><b>BLACK</b>                                                                                                                                        |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>8 31 18</b>                                                                       |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                          |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                                                                                              |  | 8 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                              |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER BALTO.MD.</b>                   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                       |                                              |
| 13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                         |  | 13b COUNTY                                                                     |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                          |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                              |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                                     |  |                                                                                                                        |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                       |  | 16b SOCIAL SECURITY NO<br><b>216-05-6253</b>                                   |  | 17 INFORMANT ADDRESS                                                                                                                                          |  |                                                                                                                        |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>metastatic pancreatic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                |  |                                                                                                                                                               |  |                                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                               |  |                                                                                                                        |                                              |
| 19a DATE OF OPERATION<br><b>5/1/79</b>                                                                                                                                                                                                                                                                                                                                               |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Pancreatic Carcinoma</b> |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                              |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                 |  |                                                                                                                        |                                              |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                 |  |                                                                                                                        |                                              |
| 22a I certify that (X) (this hospital) attended the deceased from <b>APRIL 6, 19 79</b> , to <b>JUNE 11, 19 79</b> , that (X) (we) lost <del>above</del> (we) did <del>not</del> view the body after death.                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                               |  |                                                                                                                        |                                              |
| 22b SIGNATURE <b>Charles Newton</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>6/11/79</b>                                                                                      |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Newton</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 22e ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTO.MD. 21218</b>                                                                                                   |  |                                                                                                                        |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                            |  | 23b DATE<br><b>6/16/79</b>                                                     |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>                                                                                                     |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                        |                                              |
| 24 FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                          |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 25b REGISTRAR'S SIGNATURE<br><i>Anthony M. Brady</i>                                                                                                          |  |                                                                                                                        |                                              |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH9 1 4 4 8 9  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JACK FIORE Niccoli</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 / 21 / 79</b>              |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>10<sup>14</sup> M</b>                                               |                                                                                                 |                                                   |                                                                                                                            |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                              |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 - 13 - 94</b>                                                                                                   |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                  |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.      |                                                                                                                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD                        |                                                                                                 |                                                   |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hosp.</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b> |                                                                                                                            |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          | 13b. COUNTY<br><b>Balto</b>                                            |                                                                                                                                                             | 13c. CITY OR TOWN                                                              |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                   | 13e. STREET ADDRESS<br><b>2916 Yorkway - 21226</b>                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Salvatore Niccoli</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANTOINETTE UNK</b>                                                                                      |                                                                                |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>212-18-2923</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mrs ANTOINETTE Terrante - same</b>              |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>492 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Emphysema, CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                          |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                                 |                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                        |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                  |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>6/16</b> , 19 <b>79</b> , to <b>6/21</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/21/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                                 |                                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>David Mishkin MD</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                | DEGREE<br><b>MD</b>                                                                |                                                                                                 | 22c. DATE SIGNED<br><b>6/21/79</b>                |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David Mishkin MD</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br><b>Balto City Hosps.</b>                                           |                                                                                                 |                                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          | 23b. DATE<br><b>6/25/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                     |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>                                  |                                                   |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LANNINO Funeral Home - 263 S. Connelley</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1000

0721 2 4 1004

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **14490**

**1- FOR  
STATE  
REGISTRAR**

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                          |                                                                                                            |                                                                                                                                                             |                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DONALD LEE NICHOLSON</b>                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                          | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 2 1979</b> |                                                                                                                                                             | 2b. HOUR<br>M<br><b>10:45 a</b>                                                     |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb 8, 1938</b>                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41 YRS.</b>                                                          | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     | IF UNDER 24 HRS.                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>                                                                         |                                                                                     |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 13b. COUNTY<br><b>P.G. Co.</b>                                                                                                           |                                                                                                            | 13c. CITY OR TOWN<br><b>Laurel</b>                                                                                                                          |                                                                                     |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                        |                         | 13e. STREET ADDRESS<br><b>6905 Goodman Rd.</b>                                                                                           |                                                                                                            |                                                                                                                                                             |                                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John A. Nicholson Sr.</b>                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret G. Bond</b>                                   |                                                                                                                                                             |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                        |                         | 16b. SOCIAL SECURITY NO.<br><b>213-34-8091</b>                                                                                           |                                                                                                            | 17. INFORMANT ADDRESS<br><b>Nancy R. Nicholson same as #13</b>                                                                                              |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Broken neck</b><br>IMMEDIATE CAUSE (a) <b>8120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                          |                         |                                                                                                                                          |                                                                                                            |                                                                                                                                                             |                                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                          |                                                                                                            |                                                                                                                                                             |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |                                                                                                            |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |                         | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>11:30 5-31-1979</b>                                                                     |                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Driver in auto-auto collision.</b>                                      |                                                                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                              |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>                                                               |                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Old Gunpowder Rd. &amp; Prince George's Md.</b>                                                     |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |                                                                                                                                          |                                                                                                            |                                                                                                                                                             |                                                                                     |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>                                                                                                                                                                                                                                                                                                                                                                                                |                         | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                      |                                                                                                            | DATE SIGNED<br><b>6-3-79</b>                                                                                                                                |                                                                                     |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |                         | ADDRESS<br><b>111 Penn St.</b>                                                                                                           |                                                                                                            |                                                                                                                                                             |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 23b. DATE<br><b>6/6/79</b>                                                                                                               |                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ivy Hill Cemetery</b>                                                                                              |                                                                                     |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel P.G. Co. Maryland</b>                                                                                                                                                                                                                                                                                                                                                          |                         | 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME, INC.</b>                                                                           |                                                                                                            |                                                                                                                                                             |                                                                                     |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25b. REGISTRAR'S SIGNATURE<br><i>History McBrady</i>                                                                                     |                                                                                                            |                                                                                                                                                             |                                                                                     |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



00001





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                            |                                                                     |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Howard A Nicola</b>                                                                                                                                                                                                                                                                                                                                                                        |                                           |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 26, 1979</b>          |                                                                                |                                                                           | 2b HOUR<br><b>9:25pm</b>                                                                                                                   |                                                                                                                            |                                                                                  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                             | 4 RACE<br><b>White</b>                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 28</b>                                                                                                        |                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS                                |                                                                           |                                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                 | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b>             |                                                                     |                                                                                |                                                                           | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>truck-driver</b>                                                     |                                                                                                                            | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Branch, Motors</b>                        |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                               |                                           |                                                                                                                                                            | 13b. COUNTY<br><b>Baltimore</b>                                     |                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Homer Nicola</b>                                                                                                                                                                                                                                                                                                                                                                     |                                           |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dove Poling</b> |                                                                                |                                                                           | 13e STREET ADDRESS<br><b>4310 E. Lombard Street</b>                                                                                        |                                                                                                                            |                                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                |                                           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217 24 9225</b>                                                                              |                                                                     | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mary Nicola 4310 E. Lombard St. 21224</b>  |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>1489</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diffuse Metastatic Neoplasm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Esophagus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                           |                                                                                                                                                            |                                                                     |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5/15/79</b><br><b>6/26/79</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Severe weight loss &amp; anemia</b>                                                                                                                                                                                                                                                      |                                           |                                                                                                                                                            |                                                                     |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 19a. DATE OF OPERATION<br><b>5/2/79</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma Esophagus</b>                                                                             |                                                                     |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>9:25 PM 5/26/1979</b>                                                                                                                                                                                                                                             |                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/26/1979</b>                                                                                        |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5/14/79</b> 19____, to <b>6/26/79</b> 19____, that (I) (we) last saw the deceased alive on <b>6/26/79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                  |                                           |                                                                                                                                                            |                                                                     |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 22a. SIGNATURE<br><b>J. P. FARRIOR MD</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                           |                                                                                                                                                            |                                                                     | DEGREE<br><b>MD</b>                                                            |                                                                           | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                            | 22b. DATE SIGNED<br><b>6/26/79</b>                                               |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FARRIOR</b>                                                                                                                                                                                                                                                                                                                                                                          |                                           |                                                                                                                                                            |                                                                     | 22e. ADDRESS<br><b>Johns Hopkins Hosp.</b>                                     |                                                                           |                                                                                                                                            |                                                                                                                            |                                                                                  |
| 23. BURIAL, CREMATION, REMOVAL (IFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                            |                                           | 23b. DATE<br><b>6/30/79</b>                                                                                                                                |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shilo Cemetery</b>                    |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Kasson W. Va.</b>                                                                         |                                                                                                                            |                                                                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski</b>                                                                                                                                                                                                                                                                                                                                                                          |                                           |                                                                                                                                                            |                                                                     | ADDRESS<br><b>1005 Dundalk Avenue</b>                                          |                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                         |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit certificate. The funeral director should remove carbon copies of this certificate and forward them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The funeral director must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

|                        |             |   |           |        |                          |
|------------------------|-------------|---|-----------|--------|--------------------------|
| Male                   | White       | 2 | 12        | 38     | 31                       |
| West Virginia          | USA         |   |           |        |                          |
| Baltimore              |             |   |           |        |                          |
| 4310 E. Lombard Street |             |   |           |        |                          |
| Home                   | Nicola      |   | Dove      |        |                          |
| no                     | 117 14 9125 |   | Mrs. Mary | Nicola | 4310 E. Lombard St. 2114 |

ES 21 280  
A 2110 13 11 10

280

Jul 1 1979  
1005 Dandak Avenue  
Walter Dabrowski  
6/30/79  
Shilo Company  
Kasson

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 9 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                        |                                                                                                                                |                                                                                                                                                             |                                                                         |                                                                                           |                                                                                                 |                                           |                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                    |                                                                                                                                | FIRST<br>JOHN                                                                                                                                               | MIDDLE<br>HENRY                                                         | LAST<br>NICOLAI, Sr.                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 1 79                                                   |                                           | 2b. HOUR<br>11 p. M.                                               |  |
| 3. SEX<br>Male                                                                                                         | 4. RACE<br>White                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 21 1910                                                                                                             |                                                                         |                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS                                                       |                                           | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. P.                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                         |                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                           |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |                                                                                                                                                             |                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired/Self-employed |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Farm |                                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |                                                                                                                                | 13b. COUNTY<br>Howard                                                                                                                                       | 13c. CITY OR TOWN<br>Ellicott City                                      |                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                           | 13e. STREET ADDRESS<br>5377 Kerger Road                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Henry August Nicolai                                                    |                                                                                                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eva Gertrude Peddicord |                                                                                           |                                                                                                 |                                           |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                             |                                                                                                                                | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>218 36 3673                                                                                       |                                                                         | 17. INFORMANT<br>Address<br>5377 Kerger Road<br>Eleanor Nicolai Ellicott City, Md. 21043  |                                                                                                 |                                           |                                                                    |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

Ruptured abdominal aortic aneurysm

24 hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

Atherosclerosis, diffuse and severe

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

MEDICAL CERTIFICATION

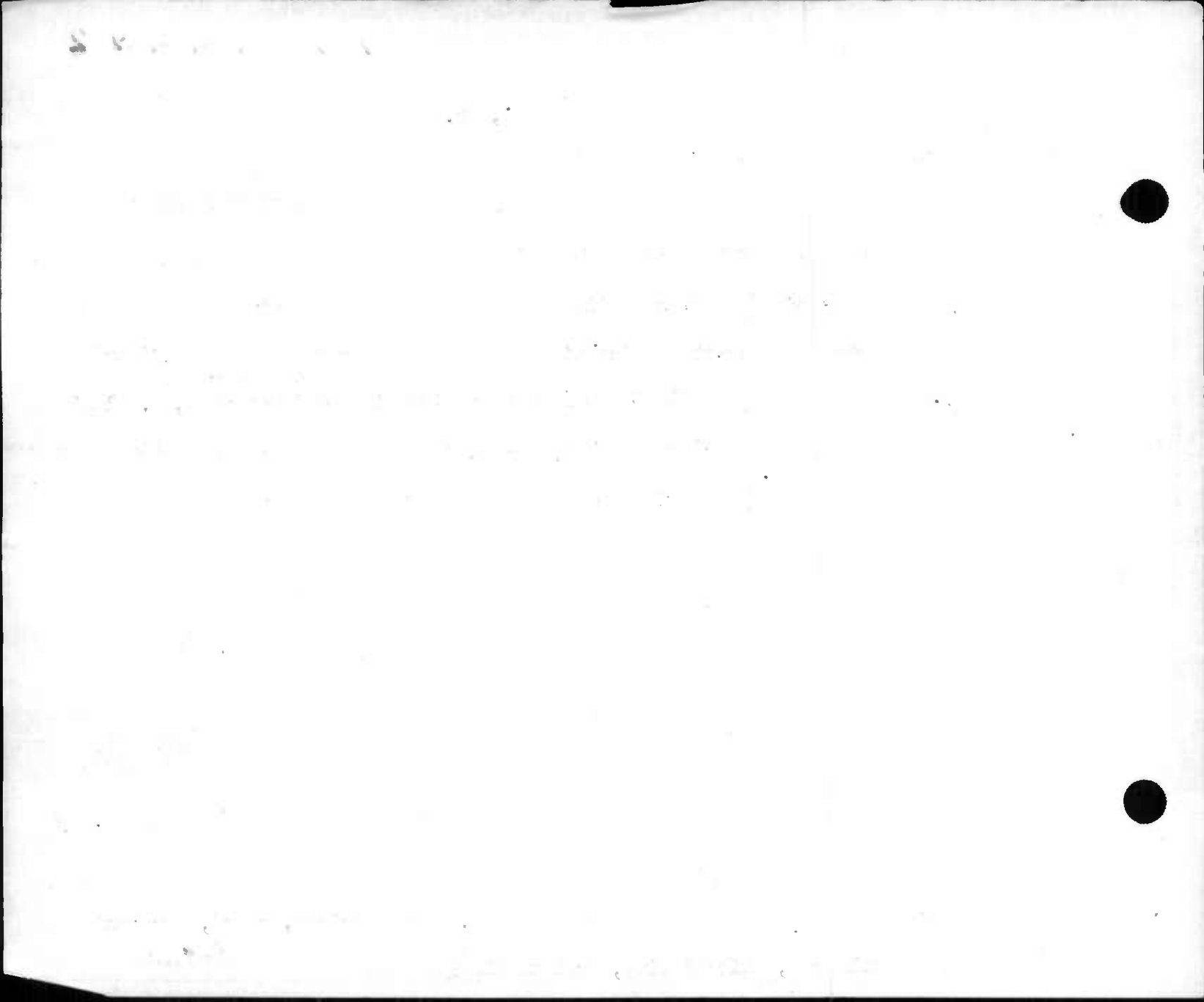
|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                               |  |                                                                                      |  |                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>6/1 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>6/1 1979                        |  |                                                                                                                                          |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>6/1</u> 19 <u>79</u> , to <u>6/1</u> 19 <u>79</u> , that (X) (we) last saw the deceased alive on <u>6/1</u> 19 <u>79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do) view the body after death. |  |                                                                               |  |                                                                                      |  |                                                                                                                                          |  |
| 22b. SIGNATURE<br>Joan E. Whitehouse M.D.                                                                                                                                                                                                                                                                                                                |  |                                                                               |  | DEGREE<br>M.D.                                                                       |  | 22c. DATE SIGNED<br>6/1/79                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOAN E. WHITEHOUSE M.D.                                                                                                                                                                                                                                                                                         |  |                                                                               |  | 22e. ADDRESS<br>900 CATON AVE., BALTIMORE, MD. 21229                                 |  |                                                                                                                                          |  |

|                                                                             |                     |                                                                                     |                                                                       |
|-----------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial                      | 23b. DATE<br>6/5/79 | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park Ellicott City, Maryland | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City, Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>SLACK Funeral Home, Ellicott City, Maryland |                     | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                         |                                                                       |
|                                                                             |                     | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                           |                                                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                                                                             |                                               |                                                                                                 |  |                                                                                                                            |  | 7 9 1 4 4 9 3 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO.                                                                                                                                              |  |                                                                                                                                                             |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>(BABY BOY) NIDER                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 8 79 |                                                                                                 |  | 2b. HOUR<br>M                                                                                                              |  |               |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>white                                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 29 79                                                                                                               |                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>10                                       |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                                                        |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |                                                                                                                            |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital (infant) |  |                                                                                                                                                             |                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |               |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br>—                                                                                                                                      |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2932 Bero Road 21227                                                                                |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Baron Leigh Weber                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Debra Nider                                                                                                     |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None                                                                                       |  | 17. INFORMANT<br>ADDRESS                                                                                                                                    |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br><u>769-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hyaline membrane disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>prematurity</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                       |  |                                                                                                                                                             |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none</u>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                             |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 19a. DATE OF OPERATION<br><u>none</u>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                                                 |  |                                                                                                                                                             |                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 29</u> , 19 <u>79</u> , to <u>June 8</u> , 19 <u>79</u> , that (I) (we) lost <u>above</u> , (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |                                                                                                                                                             |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 22b. SIGNATURE<br><u>Marionne Frndberg MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                               |                                                                                                 |  | 22c. DATE SIGNED<br><u>4/8/79</u>                                                                                          |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Marionne Frndberg MD</u>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  | 22e. ADDRESS<br><u>22 S GREEN ST, BALTIMORE, MD</u>                                                                                                         |                                               |                                                                                                 |  |                                                                                                                            |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Removal</u>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><u>6/14/79</u>                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                            |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Anatomy Board</u>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  | ADDRESS<br><u>Balto., Md.</u>                                                                                                                               |                                               | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 20 1979</u>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McCreedy</u>                                                                     |  |               |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |                                                         |                                                                                                                                                             |                                                                                  |                                                                                                                            |                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROBERT Edward NOBLE</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 1, 1979</b> |                                                                                                                                                             | 2b. HOUR<br><b>11:50A</b>                                                        |                                                                                                                            |                                                     |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                         | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 26 1930</b>                                                                                                         |                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>49</b>                                                   |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                         |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Welding</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                               |  |                                                                                                                                                |                                                         | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                |                                                                                  | 13c. CITY OR TOWN<br><b>Lutherville</b>                                                                                    |                                                     |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |                                                         | 13e. STREET ADDRESS<br><b>9 Briarfield Court, Lutherville</b>                                                                                               |                                                                                  |                                                                                                                            |                                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Noble</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Margaret Trainor</b>                                                                                       |                                                                                  |                                                                                                                            |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 087-20-1963</b>                                                            |                                                         | 17. INFORMANT ADDRESS<br><b>Mrs. Diane L. Noble, 9 Briarfield Ct.</b>                                                                                       |                                                                                  |                                                                                                                            |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>coronary pulmonary arrest</b><br>2050<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AML</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                                |                                                         |                                                                                                                                                             |                                                                                  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                         |                                                                                                                                                             |                                                                                  |                                                                                                                            |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                  |                                                                                                                            |                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |                                                         | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                  |                                                                                                                            |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 20, 1979</b> to <b>6/1</b> 1979, that (I) (we) last saw the deceased alive on <b>6/1</b> 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |                                                                                                                                                |                                                         |                                                                                                                                                             |                                                                                  |                                                                                                                            |                                                     |  |
| 22b. SIGNATURE<br><b>Johns Hopkins, Md</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                         | DEGREE<br><b>Physician</b>                                                                                                                                  |                                                                                  | 22c. DATE SIGNED<br><b>6/1/79</b>                                                                                          |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J F Freeland</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |                                                         | 22e. ADDRESS<br><b>Johns Hopkins Hosp</b>                                                                                                                   |                                                                                  |                                                                                                                            |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>6/5/79</b>                                                                                                                     |                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Cemetery</b>                                                                                             |                                                                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Lake George, N. Y.</b>                                                       |                                                     |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>J. E. Lowell Lemmon</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1979</b>                                                                                                          |                                                                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. Henry</b>                                                                      |                                                     |  |
| 24. ADDRESS<br><b>10 W. Padonia Rd.</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |                                                         |                                                                                                                                                             |                                                                                  |                                                                                                                            |                                                     |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only "I", "my", or "our", the deceased must be notified in case of a change of residence.





1. [Illegible text]

2. [Illegible text]

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99. [Illegible text]

100. [Illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 4 9 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                            |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                  |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                   |                                   |
| Ernest                                                                                                                                                                                                                                                                                                            |                                                                                                        | 6-5-79                                                                                                                                                   |                                                                     | 3:45 AM                    |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                            | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR         |                                   |
| 1 Male                                                                                                                                                                                                                                                                                                            | Black                                                                                                  | 12 13 00                                                                                                                                                 | 78 YRS                                                              | IF UNDER 24 HRS            |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                            |                                   |
| Md.                                                                                                                                                                                                                                                                                                               | Balto.                                                                                                 |                                                                                                                                                          | Baltimore City MD.                                                  |                            |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                            | 12b. KIND OF BUSINESS OR INDUSTRY |
| Balto.                                                                                                                                                                                                                                                                                                            | John Deaton Med. CTR.                                                                                  |                                                                                                                                                          |                                                                     |                            |                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                      | 13b. STATE                                                                                             | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS        |                                   |
| Md.                                                                                                                                                                                                                                                                                                               | Balto.                                                                                                 |                                                                                                                                                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3166 Elmora Ave.           |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                          | 16. ADDRESS                                                         |                            |                                   |
| Unkn                                                                                                                                                                                                                                                                                                              | Unkn                                                                                                   |                                                                                                                                                          | Bertha Ruben 3166 Elmora Ave.                                       |                            |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                 | 16b. SOCIAL SECURITY NO                                                                                | 17. INFORMANT                                                                                                                                            |                                                                     |                            |                                   |
| No                                                                                                                                                                                                                                                                                                                | 218-10-9047                                                                                            | Bertha Ruben                                                                                                                                             |                                                                     |                            |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate &amp; Metastases</u> TO BONE                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| 185- DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY?                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                            |                                   |
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                     |                            |                                   |
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |                            |                                   |
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 7 1978, to June 6 1979, that (I) (we) last saw the deceased alive on June 6 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                    | DEGREE                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                                                     | 22c. DATE SIGNED           |                                   |
| Julian W. Reed                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     | 6/5/79                     |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                             | 22e. ADDRESS                                                                                           |                                                                                                                                                          |                                                                     |                            |                                   |
| JULIAN W. REED M.D.                                                                                                                                                                                                                                                                                               | 611 S. CHAS ST BALTO. MD. 21208                                                                        |                                                                                                                                                          |                                                                     |                            |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                         | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                            |                                   |
| Burial                                                                                                                                                                                                                                                                                                            | 6/9/79                                                                                                 | King Mem. Park                                                                                                                                           | Baltimore Co., Md.                                                  |                            |                                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                         |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                     | 25b. REGISTRAR'S SIGNATURE |                                   |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                 |                                                                                                        | JUN 7 1979                                                                                                                                               |                                                                     | [Signature]                |                                   |

67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

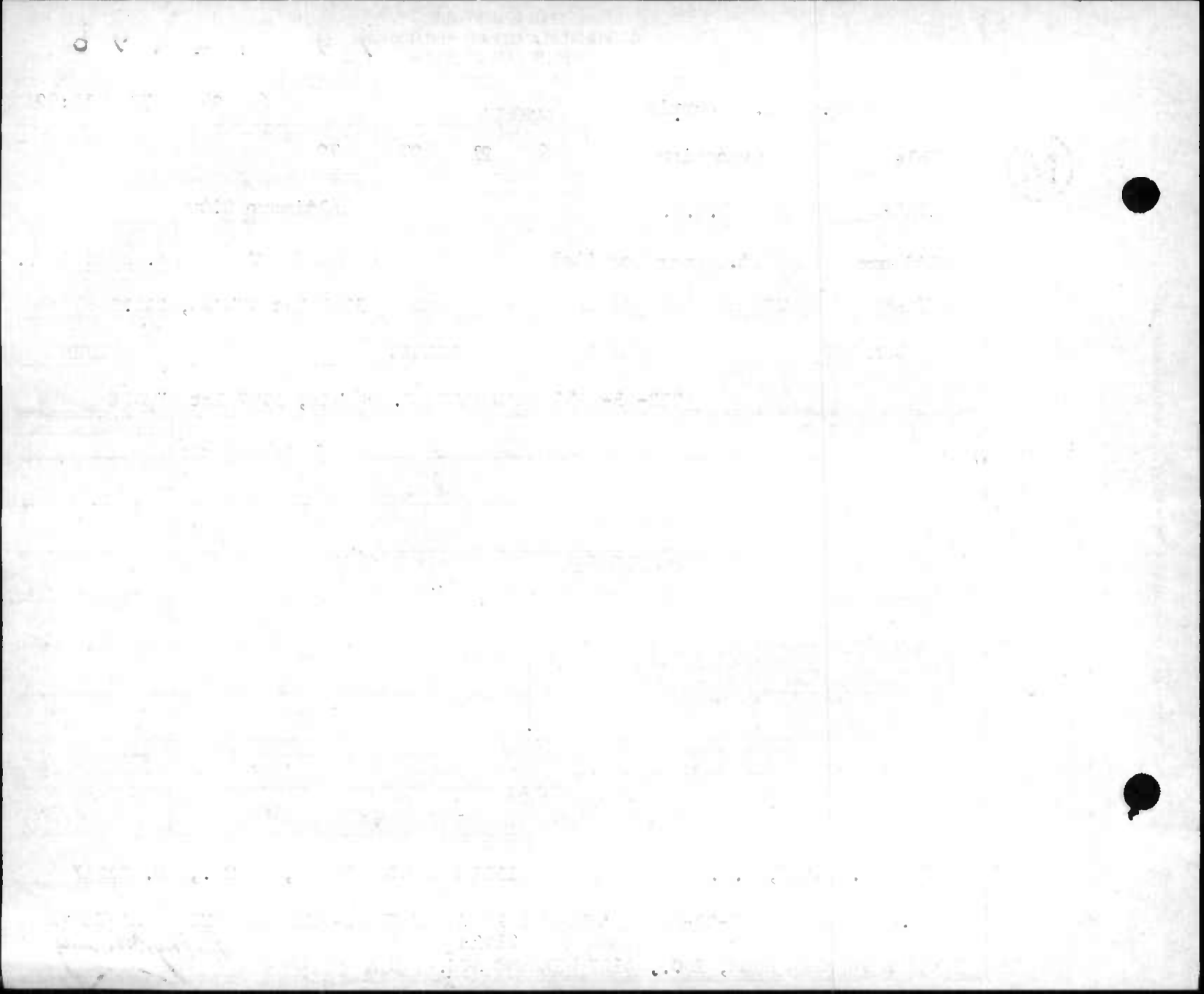
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|------------------------|------|------------|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE | LAST                                                                           | 2a. DATE OF DEATH                                                   | MONTH                                                          | DAY                    | YEAR | 2b. HOUR   | MIN. |
| JAMES A. NORRIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |        |                                                                                | 6                                                                   | 24                                                             | 79                     |      | 11:02A     |      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                                | IF UNDER 1 YEAR                                                     |                                                                | IF UNDER 24 HRS.       |      |            |      |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Caucasian                                                                                                 | MONTH 6 DAY 21 YEAR 07                                                                                                                                      |        | 72                                                                             | MONTHS                                                              |                                                                | DAYS                   |      | HOURS MIN. |      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                     |                                                                |                        |      |            |      |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | U.S.A.                                                                                                    |                                                                                                                                                             |        | Baltimore City                                                                 |                                                                     |                                                                |                        |      |            | MD   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                              |                        |      |            |      |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | St. Agnes Hospital                                                                                        |                                                                                                                                                             |        | MACHINIST                                                                      |                                                                     | A. HOEN & CO.                                                  |                        |      |            |      |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 13b. COUNTY                                                                                                                                                 |        | 13c. CITY OR TOWN                                                              | 13d. INSIDE CITY LIMITS?                                            |                                                                | 13e. STREET ADDRESS    |      |            |      |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | BALTIMORE                                                                                                                                                   |        | HALETHORPE                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                | 5707 1st AVENUE, 21227 |      |            |      |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | FIRST MIDDLE LAST                                                                                                                                           |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
| CHARLES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | LILLIE                                                                                                                                                      |        |                                                                                |                                                                     |                                                                |                        |      |            | KUHL |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |        | 17. INFORMANT                                                                  |                                                                     | ADDRESS                                                        |                        |      |            |      |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | 213-03-8036                                                                                                                                                 |        | FLORENCE D. NORRIS,                                                            |                                                                     | 5707 1st AVENUE                                                |                        |      |            |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Closed Head Injury</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>poison from toxic</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chained bullets to Cephalic Vessels</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chained bullets to Cephalic Vessels</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |        | 20a. AUTOPSY?                                                                  |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                        |      |            |      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |        | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                        |      |            |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                     |                                                                |                        |      |            |      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                     |                                                                |                        |      |            |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> 19 <u>79</u> to <u>6/24</u> 19 <u>79</u> , that (I) (we) lost <u>6/24</u> 19 <u>79</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | DEGREE                                                                                                                                                      |        | 22c. DATE SIGNED                                                               |                                                                     |                                                                |                        |      |            |      |
| <u>John C. Healy</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |        | 6/24/79                                                                        |                                                                     |                                                                |                        |      |            |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 22e. ADDRESS                                                                                                                                                |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
| JOHN C. HEALY, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 1311 FRANCIS AVENUE, BALTO., MD. 21227                                                                                                                      |        |                                                                                |                                                                     |                                                                |                        |      |            |      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 23b. DATE                                                                                                                                                   |        | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                        |      |            |      |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 06-27-79                                                                                                                                                    |        | LOUDON PARK CEMETERY                                                           |                                                                     | BALTIMORE CITY MARYLAND                                        |                        |      |            |      |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | ADDRESS                                                                                                                                                     |        | 25a. DATE REC'D. BY REGISTRAR                                                  |                                                                     | 25b. REGISTRAR'S SIGNATURE                                     |                        |      |            |      |
| HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 4107 WILKENS AVE.                                                                                                                                           |        | JUN 25 1979                                                                    |                                                                     | <u>Anthony M. Brady</u>                                        |                        |      |            |      |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, put in

**TO FUNERAL DIRECTOR:** After this certificate has

to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DHMH - 16 50M 7/77  
(VR A 15 (4))

25a. DATE PAID BY REQUESTER **JUN 5 1979**



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |                                                                                                                                       | 7 9 1 4 4 9 8<br>REG. NO.                              |                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>SOPHIA</u> MIDDLE <u>NORWOOD</u> LAST <u>SOPHIA</u>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>June 27 1979</u>                                                                                                     |                                                                                                                                       | 2b. HOUR<br>M                                          |                  |
| 3. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><u>White</u>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>Dec. 22, 1885</u>                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>93</u> YRS.                                                                                     | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.           | 8. UNDER 24 HRS. |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7c. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                                                                     |                                                        |                  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNION MEMORIAL HOSPITAL</u> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Clerk</u>                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Shoe Store</u> |                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                     | 13c. CITY OR TOWN<br><u>Baltimore</u>                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS<br><u>2405 Hamilton Ave.</u>                                                                                      |                                                        |                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Charles Eisenreich</u>                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Margaret Imhoff</u>                                                                     | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>                                                |                                                                                                                                       |                                                        |                  |
| 17. SOCIAL SECURITY NO.<br><u>215-10-6610</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 18. INFORMANT ADDRESS<br><u>Millicent Troutman 2405 Hamilton Ave.</u>                                                                       |                                                                                                                                                             |                                                                                                                                       |                                                        |                  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR SHOCK</u><br>2765<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>DEHYDRATION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SENILE DEMENTIA</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 HOURS</u><br><u>WEEK</u><br><u>YEARS</u> |                                                                                                                                             |                                                                                                                                                             |                                                                                                                                       |                                                        |                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>URINARY TRACT INFECTION</u>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                                                                       |                                                        |                  |
| 19a. DATE OF OPERATION<br><u>6/27</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>6/26</u>                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                        |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                                                       |                                                        |                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                       |                                                        |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> 19 <u>79</u> to <u>6/27</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/27</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                                                                                                    |                                                                                                                                             |                                                                                                                                                             |                                                                                                                                       |                                                        |                  |
| 22b. SIGNATURE<br><u>P. Disharoon, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       | DEGREE<br><u>M.D.</u>                                                                                                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                                                                                                       | 22c. DATE SIGNED<br><u>6/27/79</u>                     |                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PATRICIA DISHAROON</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                             | 22e. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>                                                                                                              |                                                                                                                                       |                                                        |                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIALLY<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     | 23b. DATE<br><u>June 29, 1979</u>                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park</u>                                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Maryland</u>                                                               | 23e. DATE REC'D. BY REGISTRAR<br><u>JUN 28 1979</u>    |                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Leonard J. Ruck, Inc. Baltimore, Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | 25. REGISTRAR'S SIGNATURE<br><u>Henry McCreedy</u>                                                                                                          |                                                                                                                                       |                                                        |                  |

8 9 1 2 3 4





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                           |                                                                 |                                                                                                                            | 7 9 1 4 4 9 9 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------|--|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                              |  | REG. NO.                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEO JOHN NUEDLING</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 7 1979</b>                      |                                                                                    |                                                                           | 2b. HOUR<br>M                                                   |                                                                                                                            |               |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>WHITE</b>                                                                                                           |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 21 1909</b>                                                                                                   |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>                                       |                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                                                            |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                   |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                  |                                                                           |                                                                 |                                                                                                                            |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2712 FAIT AVE</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ESSKAY</b>              |                                                                                                                            |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                             |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                             |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                                | 13e. STREET ADDRESS<br><b>2712 FAIT AVE.</b>                                       |                                                                           |                                                                 |                                                                                                                            |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN NUEDLING</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH SCHNIEDER</b>                                                                                 |                                                                                |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                                | 17. INFORMANT<br>ADDRESS<br><b>EVELYN NUEDLING 2712 FAIT AVE</b>                   |                                                                           |                                                                 |                                                                                                                            |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Malignant Lymphoma with generalized metastasis 1 yr.</b><br>2028<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)     |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                       |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                            |  |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 22a. I certify that (I) <del>did not</del> attended the deceased from <b>11-8</b> , 19 <b>66</b> , to <b>6-7</b> , 19 <b>79</b> , that (I) <del>lost</del> saw the deceased alive on <b>6-7</b> , 19 <b>79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> (did not) view the body after death. |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 22b. SIGNATURE<br><b>Melito M. Torres</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                            |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br><b>6-11-79</b>                                                 |                                                                           |                                                                 |                                                                                                                            |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Melito M. Torres, M.D.</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>441 S. Ellwood Ave. Baltimore, Md., 21224</b>               |                                                                                    |                                                                           |                                                                 |                                                                                                                            |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   | 23b. DATE<br><b>6/11/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART OF JESUS</b>             |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>        |                                                                 |                                                                                                                            |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond H. KACZOROWSKI</b> ADDRESS<br><b>2525 FLEET ST.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                            |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Henry K. Brady</b>                       |                                                                 |                                                                                                                            |               |  |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14500

|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                            |                                                |                                                                                                                                                             |                                |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bessie L. O'Brien                                                                                                                                                                                                                                                                        |  |                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 10 79 |                                                                                                                                                             | 2b. HOUR<br>4 <sup>30</sup> AM |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>Caucasian                                                                                                       |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>City Hospital |                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |                                                | 13b. COUNTY<br>Baltimore                                                                                                                                    |                                | 13c. CITY OR TOWN<br>Baltimore                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |                                |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>220-07-8390                                                                                    |                                                | 17. INFORMANT<br>ADDRESS<br>Linwood Jarrell Jr. 6717 Harford Rd.                                                                                            |                                |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardio - Pulmonary arrest.<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Organic Brain Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ASCVD<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                            |                                                |                                                                                                                                                             |                                |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)                                                                                                                                                                                             |  |                                                                                                                            |                                                |                                                                                                                                                             |                                |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                 |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                     |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |                                                                                                                            |                                                |                                                                                                                                                             |                                |                                                                                                                            |  |
| 22b. SIGNATURE<br>R. Pat Riley                                                                                                                                                                                                                                                                                                  |  |                                                                                                                            |                                                | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                                | 22c. DATE SIGNED<br>6-10-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. PAT RILEY                                                                                                                                                                                                                                                                           |  |                                                                                                                            |                                                | 22e. ADDRESS                                                                                                                                                |                                |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>6/12/79                                                                                                       |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill                                                                                                            |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD.                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John J. Grant                                                                                                                                                                                                                                                                                   |  |                                                                                                                            |                                                | ADDRESS<br>1211 Chesaco Ave.                                                                                                                                |                                | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                            |                                                | 25b. REGISTRAR'S SIGNATURE<br>Anthony M. Brady                                                                                                              |                                |                                                                                                                            |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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14501

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                   |                                                                                                                                                             |                                                                                |                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE RITA LAST O'CONNOR                                                                                                                                                                                                                                                                                                                                |                                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-4-79<br>2b. HOUR<br>9:10 P.M.         |                                                                                                 |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 23 94                                                                                                               |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 85<br>IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK NURSING HOME |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper |                                                                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md.                                                                                                                                                                                                                                                                                             |                                                                                                                                   | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>Balto                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Timothy J. O'Connor                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Belbert                                                                                          |                                                                                |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>215-10-4574                                                                                                                     |                                                                                | 17. INFORMANT<br>ADDRESS<br>Dorothy O Giarth 4401 Roland Ave                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (d) Aspiration pneumonia<br>3330<br>DUE TO, OR AS A CONSEQUENCE OF Dysphagia<br>DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic parkinsonism<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>36 hours<br>1 week<br>3 years |                                                                                                                                   |                                                                                                                                                             |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.                                                                                                                                                                                                                                                                           |                                                                                                                                   |                                                                                                                                                             |                                                                                |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |                                                                                                                                   |                                                                                                                                                             |                                                                                |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |
| 22a. I certify that (this hospital) attended the deceased from Jan 16, 1979 to June 4, 1979, that (I) saw the deceased alive on June 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                     |                                                                                                                                   |                                                                                                                                                             |                                                                                |                                                                                                 |
| 22b. SIGNATURE<br>W.B. Daniels, Jr.                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   | DEGREE<br>M.D.                                                                                                                                              |                                                                                | 22c. DATE SIGNED<br>6/4/79                                                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W.B. Daniels, Jr.                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                   | 22e. ADDRESS<br>Keswick<br>200 W. 40th St. Baltimore 21211                                                                                                  |                                                                                |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   | 23b. DATE<br>6/7/1979                                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                   |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                   |                                                                                                                                                             |                                                                                |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                   | ADDRESS<br>6500 York Rd.                                                                                                                                    |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>JUN 7 1979                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                   | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.                                                                                                                   |                                                                                |                                                                                                 |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14502

|                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                   |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                       |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                       |
| John F. Oechsler                                                                                                                                                                                                                                                                                                         |                                                                                                        | June 20, 1979                                                                                                                                            |                                                                     | 4:15 AM                                                                        |                       |
| 3. SEX                                                                                                                                                                                                                                                                                                                   | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                                                                |                       |
| Male                                                                                                                                                                                                                                                                                                                     | White                                                                                                  | 7 13 1896                                                                                                                                                | 82                                                                  | IF UNDER 24 HRS                                                                |                       |
| 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                             |                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                       |
| Maryland                                                                                                                                                                                                                                                                                                                 |                                                                                                        | U.S.A.                                                                                                                                                   |                                                                     | Baltimore City MD.                                                             |                       |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                                | 12b. INDUSTRY         |
| Baltimore                                                                                                                                                                                                                                                                                                                | Baltimore City Hospitals                                                                               |                                                                                                                                                          | Crane Oper.                                                         |                                                                                | American Smelting Co. |
| 13a. STATE                                                                                                                                                                                                                                                                                                               | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |                       |
| Maryland                                                                                                                                                                                                                                                                                                                 |                                                                                                        | Baltimore                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 21224 417 North Rose Street                                                    |                       |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                        |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |                       |
| Theodore Oechsler                                                                                                                                                                                                                                                                                                        |                                                                                                        | Margaret Detzer                                                                                                                                          |                                                                     | 16b. SOCIAL SECURITY NO.                                                       |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     | 212-10-1433                                                                    |                       |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                            |                                                                                                        | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                                |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |                       |
| Andrew F. Oechsler-Balto.                                                                                                                                                                                                                                                                                                |                                                                                                        | Cardio-Pulmonary arrest                                                                                                                                  |                                                                     |                                                                                |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |                                                                     |                                                                                |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |                                                                     |                                                                                |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |                                                                     |                                                                                |                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                  |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                                     |                                                                                |                       |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                     |                                                                                |                       |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                     |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION                                                                  |                       |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     | STREET CITY OR TOWN COUNTY STATE                                               |                       |
| 22a. I certify that (I) (this hospital) attended the deceased from June 15, 1979, to June 20, 1979, that (I) (we) last saw the deceased alive on June 20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                       |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                           |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                               |                       |
| Walter J. Leon MD                                                                                                                                                                                                                                                                                                        |                                                                                                        | MD                                                                                                                                                       |                                                                     | 6/20/79                                                                        |                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                                |                       |
| WALTER J. LEON                                                                                                                                                                                                                                                                                                           |                                                                                                        | Baltimore City Hospital                                                                                                                                  |                                                                     |                                                                                |                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                |                                                                                                        | 23b. DATE                                                                                                                                                |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                             |                       |
| Burial                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 6/22/79                                                                                                                                                  |                                                                     | Meadowridge Mem.                                                               |                       |
| 23d. LOCATION                                                                                                                                                                                                                                                                                                            |                                                                                                        | 23e. COUNTY                                                                                                                                              |                                                                     | 23f. STATE                                                                     |                       |
| Dorsey                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     | Maryland                                                                       |                       |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                     |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                       |
| Duda-Ruck, Inc.                                                                                                                                                                                                                                                                                                          |                                                                                                        | JUN 22 1979                                                                                                                                              |                                                                     | R. J. Ruck                                                                     |                       |
| 7922 Wise Avenue, Dundalk, MD 21222                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                       |

50241 28



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14503

FOR  
1. STATE  
REGISTRAR

|                                                                                                                   |                  |                                                                    |  |                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Toney Oliver                                                               |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-16-79                     |  | 2b. HOUR<br>10:30 AM                                                                                                                                        |  |
| 3. SEX<br>Male                                                                                                    | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-16-25                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS                                                                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Unknown                                                              |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City, Balt.                                                               |                  | 10. CITY OR TOWN OF DEATH<br>City                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lob. etc.                                      |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |                  | 13b. COUNTY<br>City                                                |  | 13c. CITY OR TOWN<br>City                                                                                                                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Johnny Oliver                                                           |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susana Livingston |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                       |  |
| 17. INFORMATION<br>18a. SOCIAL SECURITY NO.<br>250-31-0753                                                        |                  | 18b. ADDRESS<br>Emma J. Oliver                                     |  | 18c. Smae                                                                                                                                                   |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

|                                                                                               |  |                                                                    |  |             |  |
|-----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|-------------|--|
| IMMEDIATE CAUSE (a)<br>1579 Cardiac arrest                                                    |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory failure          |  | 16. 15      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) Metabolic pancreatic disease |  | 17. 4 weeks |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Subarachnoid aneurysm

|                                                                                                                                                          |  |                                                                                        |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br>5/21/79                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Obstructive jaundice - Ca Pancreas |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>above, (I) (we) (did) (did not) view the body after death                          |  | 4/26/79 to 6/16/79                                                                     |  | that (I) (we) lost                                                                   |  |
| 22b. SIGNATURE<br>PELOYO E. CORREA                                                                                                                       |  | DEGREE<br>MD                                                                           |  | 22c. DATE SIGNED<br>6/16/79                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                    |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL                                                      |  |                                                                                      |  |

|                                                              |  |                                                                           |  |                                                       |  |
|--------------------------------------------------------------|--|---------------------------------------------------------------------------|--|-------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial       |  | 23b. DATE<br>6/21/79                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem. |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H 1101 E. North Ave. |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979          |  |
|                                                              |  |                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br>L. H. H. H.             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 6 2 1 1 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 0 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR            |  |
| JOHN REMSEN ONDERDONK                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 6/13/79                                                                                                                                                  |                                                                     | 10 <sup>35</sup> PM |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                              | 4 RACE                                                                                                 | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR     |  |
| M                                                                                                                                                                                                                                                                                                                                                                  | W                                                                                                      | October 10, 1907                                                                                                                                         | 71                                                                  | IF UNDER 24 HRS     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                     |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                | USA                                                                                                    |                                                                                                                                                          | BALTIMORE CITY MD.                                                  |                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                     |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                          | UNION MEMORIAL HOSPITAL                                                                                | Engineer                                                                                                                                                 | Electrical                                                          |                     |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                         | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | Baltimore                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 105 W. 39th St.     |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                          |                                                                     |                     |  |
| John Remsen Onderdonk                                                                                                                                                                                                                                                                                                                                              | Alexandrina S. Barton                                                                                  |                                                                                                                                                          |                                                                     |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                  | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT                                                                                                                                            | ADDRESS                                                             |                     |  |
| No                                                                                                                                                                                                                                                                                                                                                                 | 718 10 7456 A                                                                                          | Mrs. Vera W. Onderdonk                                                                                                                                   | 105 W. 39th St.                                                     |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY?                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                     |  |
|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 | 21b. TIME OF INJURY                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                     |                     |  |
|                                                                                                                                                                                                                                                                                                                                                                    | HOUR A.M. MONTH DAY YEAR                                                                               |                                                                                                                                                          |                                                                     |                     |  |
|                                                                                                                                                                                                                                                                                                                                                                    | P.M. 19                                                                                                |                                                                                                                                                          |                                                                     |                     |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION                                                                                                                                            |                                                                     |                     |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                  |                                                                                                        | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                                                                     |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>79</u> , to <u>6/13</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                     | DEGREE                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               | 22c. DATE SIGNED                                                    |                     |  |
| <u>Benjamin K. Yorkoff, MD</u>                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          | 6/13/79                                                             |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                              | 22e. ADDRESS                                                                                           |                                                                                                                                                          |                                                                     |                     |  |
| <u>Benjamin K. Yorkoff</u>                                                                                                                                                                                                                                                                                                                                         | <u>Union MEMORIAL HOSPITAL</u>                                                                         |                                                                                                                                                          |                                                                     |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                          | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION                                                       |                     |  |
| Cremation                                                                                                                                                                                                                                                                                                                                                          | 6/18/79                                                                                                | Green Mount Cem.                                                                                                                                         | Baltimore, Md.                                                      |                     |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                               | 25a. DATE REC'D. BY REGISTRAR                                                                          |                                                                                                                                                          | 25b. REGISTRAR'S SIGNATURE                                          |                     |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                       | JUN 19 1979                                                                                            |                                                                                                                                                          | <u>Henry M. Brady</u>                                               |                     |  |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     |                     |  |

1500

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14505

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                        |                                                                                                                                                             |                                                                                         |                                                                                             |                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARRY F. O'NEIL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 / 11 / 79</b>                               |                                                                                             | 2b. HOUR<br><b>4:30 A</b>                           |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>White</b>                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 22, 1927</b>                                                                                                  |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS<br>IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. |                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                           |                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN EACH FACILITY, GIVE STREET ADDRESS)<br><b>3885 Sinclair Lane</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |                                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b> |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                         |                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Evert O'Neil</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola Brawble</b>                   |                                                                                             |                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>26 Korean 16 230-30-7684</b>                                                                  |                                                                                         | 17. INFORMANT<br>ADDRESS<br><b>Mrs Zelma O'Neil 3885 Sinclair Lane</b>                      |                                                     |
| 18. CAUSE OF DEATH (Enter on one line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>sudden death - probable myocardial infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertension, diabetes, previous MI's</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                        |                                                                                                                                                             |                                                                                         |                                                                                             |                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>chronic obstructive pulmonary disease</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                        |                                                                                                                                                             |                                                                                         |                                                                                             |                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |                                                     |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                        |                                                                                                                                                             |                                                                                         |                                                                                             |                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                           |                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>78</b> , to <b>June 11</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>4/10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                                                                                                                                |                                                                                                                                        |                                                                                                                                                             |                                                                                         |                                                                                             |                                                     |
| 22b. SIGNATURE<br><b>Angela C Healy MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                        | DEGREE                                                                                                                                                      |                                                                                         | 22c. DATE SIGNED<br><b>6/11/79</b>                                                          |                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Angela C Healy MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                        | 22e. ADDRESS<br><b>Baltimore City Hospitals, 4940 Eastern Ave</b>                                                                                           |                                                                                         |                                                                                             |                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        | 23b. DATE<br><b>6-15-1979</b>                                                                                                                               |                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn</b>                                     |                                                     |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard County, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        |                                                                                                                                                             |                                                                                         |                                                                                             |                                                     |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                             |                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>                                         |                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                        |                                                                                                                                                             |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Fisher</b>                                                 |                                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 0 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                             |  |                                                                                                                                          |                                                                                 |                                                                                                                                                            |                           |                                                                                                 |  |                                                                    |  |                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANTHONY PAUL ORBAN</b>                                                                                                        |  |                                                                                                                                          | 2a DATE OF DEATH MONTH DAY YEAR<br><b>6 15 79</b>                               |                                                                                                                                                            | 2b HOUR<br><b>1 20 PM</b> |                                                                                                 |  |                                                                    |  |                                                                  |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                        |  | 4 RACE<br><b>Caucasian</b>                                                                                                               |                                                                                 | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>April 7, 1895</b>                                                                                                     |                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                                |  | 7a IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0 0</b>                     |  | 7b IF UNDER 2 YEARS HOURS MIN.<br><b>0 0</b>                     |  |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                 |  | 7d CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                                 | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |                                                                    |  |                                                                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH INSTITUTION, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |                                                                                 |                                                                                                                                                            |                           | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Balt. Co. Fire Chief</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Gov't.</b>                  |  |                                                                  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b> |  |                                                                                                                                          |                                                                                 |                                                                                                                                                            |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>100 Locust Drive 21228</b>               |  |                                                                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Orban</b>                                                                                                                                  |  |                                                                                                                                          | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Welansics</b> |                                                                                                                                                            |                           | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>                  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW I</b> |  | 17 INFORMANT ADDRESS<br><b>Mrs. Sarah M. Peters Same as # 13</b> |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I: DEATH WAS CAUSED BYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

**CEREBRO - VASCULAR ACCIDENT****3 days**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                       |  |                                                                                                                                                      |  |                                                                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                        |  |                                                                                                                              |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                            |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                     |  |                                                                                                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>June 12, 19 79</b> , to <b>June 15, 19 79</b> , that (I) (we) last<br>saw the deceased alive on <b>June 15, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                       |  |                                                                                                                                                      |  |                                                                                                                              |  |
| 22b SIGNATURE<br><b>C. d. ARCANQUES</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>6-15-79</b>                                                                                            |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. d. ARCANQUES</b>                                                                                                                                                                                                                                                                                           |  |                                                                       |  | 22e ADDRESS<br><b>ST AGNES Hosp. 900 CATONA, BALTIMORE</b>                                                                                           |  |                                                                                                                              |  |

|                                                                                           |  |                            |  |                                                                    |  |                                                                                |  |
|-------------------------------------------------------------------------------------------|--|----------------------------|--|--------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                           |  | 23b DATE<br><b>6/16/79</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Security Process, Inc.</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Baltimore, Md.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MacNabb Funeral Home Catonsville, Md. 21228</b> |  |                            |  | 25a DATE REC'D BY REGISTRAR<br><b>JUN 18 1979</b>                  |  | 25b REGISTRAR'S SIGNATURE<br><b>Fifty Kelly</b>                                |  |

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/11/11



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REC. NO. 18714507

|                                                                               |  |                                                                                                                                         |                                                      |                                                                                                                                                            |                        |                                                                                      |  |                                             |  |                                 |  |                         |  |
|-------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------|--|---------------------------------------------|--|---------------------------------|--|-------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Emily M. Oreamuno |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 16, 1979 |                                                                                                                                                            | 2b. HOUR<br>10:00 A.M. |                                                                                      |  |                                             |  |                                 |  |                         |  |
| 3 SEX<br>Female                                                               |  | 4 RACE<br>White                                                                                                                         |                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 1, 1903                                                                                                           |                        | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS                                             |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | 8 IF UNDER 24 HRS<br>HOURS MIN. |  |                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Costa Rica                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                    |                                                      | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                            |  |                                             |  |                                 |  |                         |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore,                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                      |                                                                                                                                                            |                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  | 12b. KIND OF BUSINESS OR INDUSTRY           |  |                                 |  |                         |  |
| 13a. STATE<br>New York                                                        |  | 13b. COUNTY<br>Flushing LI                                                                                                              |                                                      | 13c. CITY OR TOWN<br>Flushing LI                                                                                                                           |                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>45-42 157th Street   |  |                                 |  |                         |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernesto Martin                       |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emilia Chavarria                                                                        |                                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>NO                                                       |                        |                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>079 26 5834     |  | 17 INFORMANT<br>Walter Oreamuno |  | ADDRESS<br>same as 13 e |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Sepsis  
5745

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) Surgery for retained common bile duct's stone

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

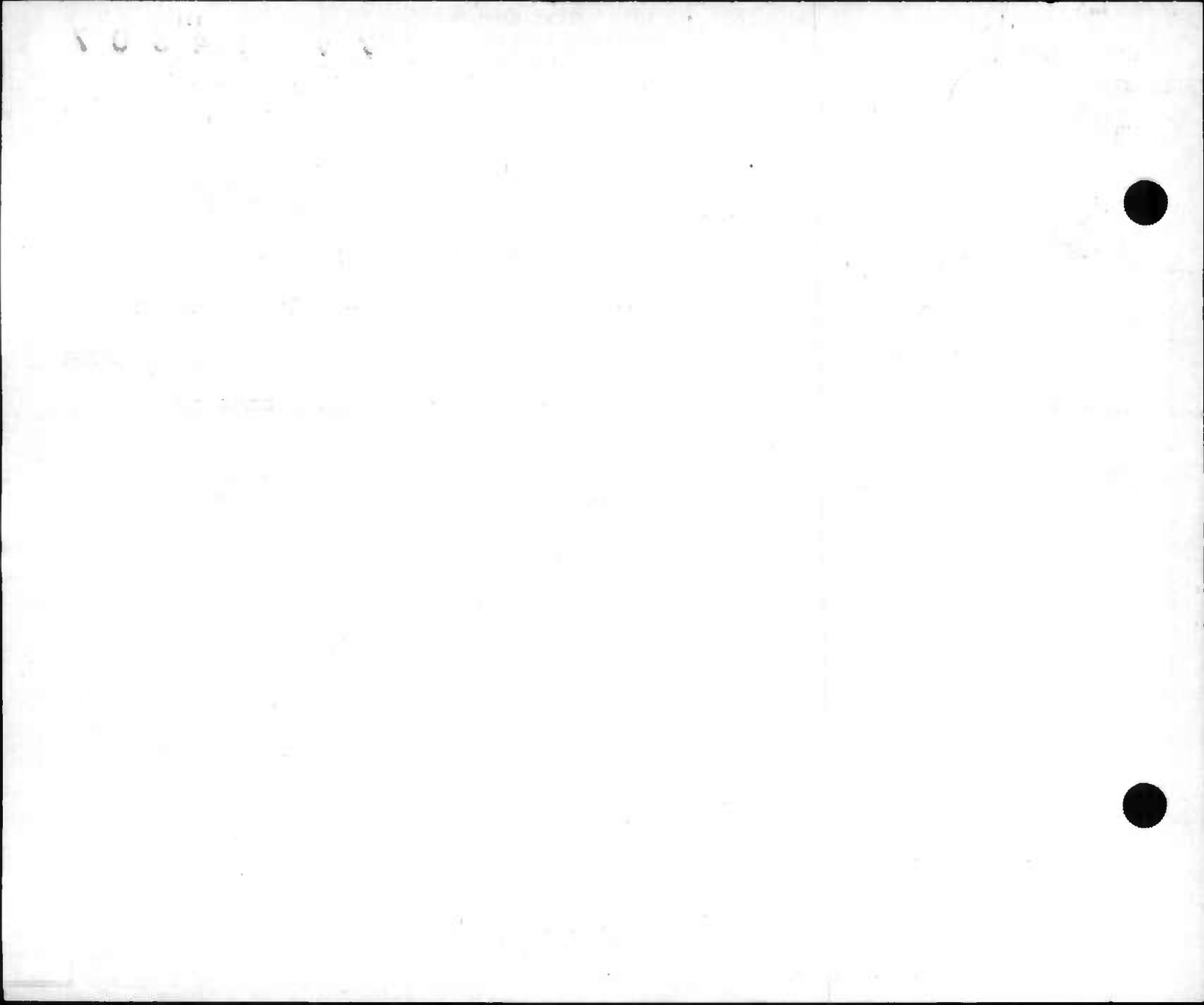
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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> , 19 <u>79</u> , to <u>6/16</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><u>Howard Frey MD</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/16/79</u>                                                                                            |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Howard Frey, MD</u>                                                                                                                                                                                                                                                                                                         |  |                                                                        |  | 22c. ADDRESS<br><u>Johns Hopkins Hospital</u>                                                                                                        |  |                                                                                                                               |  |

|                                                        |  |                      |  |                                                          |  |                                                                   |  |                                                     |  |
|--------------------------------------------------------|--|----------------------|--|----------------------------------------------------------|--|-------------------------------------------------------------------|--|-----------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>6/19/79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. St. Mary's Cem |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Flushing Long Island York |  |                                                     |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>George J. Gonce         |  |                      |  | ADDRESS<br>Balto 21225<br>4001 Ritchie Hwy               |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McBrady</u> |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14508

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------|--|-----------------|--|-------------------------------------------------------------------------------------|--|-------|--|----------|--|-------------------------------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                     |         | FIRST                                                                                                      |  | MIDDLE                                                                                |  | LAST                                                                                            |  | 2a. DATE KNOWN<br>OF ESTI. MATED    |  | MONTH           |  | DAY                                                                                 |  | YEAR  |  | 2b. HOUR |  |                                                 |  |          |  |
| Zodik                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |  |                                                                                       |  | Ostapuk<br>Ostatuk                                                                              |  | <input checked="" type="checkbox"/> |  | 6               |  | 30                                                                                  |  | 1979  |  | 8:15 PM  |  |                                                 |  |          |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE | 5. DATE OF BIRTH                                                                                           |  | YEAR                                                                                  |  | 6. AGE (IN YEARS)                                                                               |  | IF UNDER 1 YR.                      |  | IF UNDER 24 HRS |  | 7c. DATE<br>PRONOUNCED<br>DEAD                                                      |  | MONTH |  | DAY      |  | YEAR                                            |  | 2d. HOUR |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                    | White   | Dec. 28, 1938                                                                                              |  |                                                                                       |  | 80 YRS.                                                                                         |  |                                     |  |                 |  | 6                                                                                   |  | 30    |  | 1979     |  |                                                 |  |          |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                            |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| Russia                                                                                                                                                                                                                                                                                                                                                                                                  |         | Russia                                                                                                     |  |                                                                                       |  | Baltimore City, MD.                                                                             |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                               |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                      |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                            |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| Baltimore City                                                                                                                                                                                                                                                                                                                                                                                          |         | 2029 Jefferson Street                                                                                      |  | Steel Worker                                                                          |  | Beth Steel                                                                                      |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                              |         | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                 |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                |         | -----                                                                                                      |  | Baltimore                                                                             |  |                                                                                                 |  | 2029 E. Jefferson St.               |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 14. FATHER'S NAME<br>FIRST                                                                                                                                                                                                                                                                                                                                                                              |         | MIDDLE                                                                                                     |  | LAST                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST                                                               |  | MIDDLE                              |  | LAST            |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| (unknown)                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  |                                                                                       |  | (unknown)                                                                                       |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                   |         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                    |  | 17. INFORMANT                                                                         |  | ADDRESS                                                                                         |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                      |         | 213-09-2976                                                                                                |  | Darlene Ostapuk                                                                       |  | 125 N. Port Street                                                                              |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which }<br>gave rise to immediate }<br>cause (a) stating the under- }<br>lying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                     |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |       |  |          |  |                                                 |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                               |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |                                                                                                 |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                            |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |                                                                                                 |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 22a. I certify that I took charge of the body as described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                     |         | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                       |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  | DATE<br>SIGNED 7/1/79                                                               |  |       |  |          |  |                                                 |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                      |         | Thomas D. Smith, M.D.                                                                                      |  |                                                                                       |  |                                                                                                 |  |                                     |  |                 |  | ADDRESS 111 Penn St. Balto., MD.                                                    |  |       |  |          |  |                                                 |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                            |         | 23b. DATE                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                    |  | 23d. LOCATION<br>CITY OR TOWN                                                                   |  | COUNTY                              |  | STATE           |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                  |         | July 3, 79                                                                                                 |  | Holy Trinity Cem.                                                                     |  | Elkridge, Maryland                                                                              |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                            |         | ADDRESS                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR                                                         |  | REGISTRAR'S SIGNATURE                                                                           |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |
| Dippel Brothers, Inc.                                                                                                                                                                                                                                                                                                                                                                                   |         | 7110 Belair Rd. 21206                                                                                      |  | JUL 3 1979                                                                            |  | [Signature]                                                                                     |  |                                     |  |                 |  |                                                                                     |  |       |  |          |  |                                                 |  |          |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF THE DELAY IS MORE THAN 24 HOURS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE AND A WRITTEN EXPLANATION SHOULD BE FURNISHED TO THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14509

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------|-------------------|---------------------------------------------------------------------------------------------------------|--|------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------|--|---------------------------------------------------------------------|--|---------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                    |  |        | FIRST MIDDLE LAST |                                                                                                         |  | 2a. DATE KNOWN OF DEATH            |  |                                                                                                                                                          | MONTH DAY YEAR |                                         |  | 2b. HOUR                                                            |  |         |  |
| WILLIAM                                                                                                                                                                                                                                                                                                                                                                                                                                |  |        | OUTLAW, Jr.       |                                                                                                         |  | 6                                  |  |                                                                                                                                                          | 12             |                                         |  | 19 79                                                               |  |         |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE |                   | 5 DATE OF BIRTH                                                                                         |  | 6 AGE (IN YEARS)                   |  | IF UNDER 1 YR.                                                                                                                                           |                | IF UNDER 24 HRS.                        |  | 7c. DATE PRONOUNCED DEAD                                            |  | 24 HOUR |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | BLACK  |                   | 6 4 26                                                                                                  |  | 53 YRS.                            |  | MONTHS DAYS                                                                                                                                              |                | HOURS MIN.                              |  | 6 12 19 79                                                          |  | 1:04A   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              |  |        |                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |  |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |         |  |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |        |                   | USA                                                                                                     |  |                                    |  |                                                                                                                                                          |                |                                         |  | BALTIMORE CITY, MD.                                                 |  |         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |        |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                |                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |         |  |
| BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                                                                                                         |  |        |                   | 1317 W. Lanvale                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             |  |        |                   | 13b. COUNTY                                                                                             |  |                                    |  | 13c. CITY OR TOWN                                                                                                                                        |                |                                         |  | 13d. INSIDE CITY LIMITS?                                            |  |         |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |        |                   |                                                                                                         |  |                                    |  | Balto.                                                                                                                                                   |                |                                         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |  |        |                   | 15. MOTHER'S MAIDEN NAME                                                                                |  |                                    |  | 13e. STREET ADDRESS                                                                                                                                      |                |                                         |  |                                                                     |  |         |  |
| William                                                                                                                                                                                                                                                                                                                                                                                                                                |  |        |                   | Outlaw, Sr.                                                                                             |  |                                    |  | Lena                                                                                                                                                     |                |                                         |  | 1317 W. Lanvale St.                                                 |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                     |  |        |                   | 16b. SOCIAL SECURITY NO.                                                                                |  |                                    |  | 17. INFORMANT                                                                                                                                            |                |                                         |  | ADDRESS                                                             |  |         |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |        |                   | WWII                                                                                                    |  |                                    |  | 219-10-1787                                                                                                                                              |                |                                         |  | Cynthia Daniels 5726 Simmonds Ave                                   |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |         |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                            |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                                |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                          |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |        |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       |  |                                    |  |                                                                                                                                                          |                |                                         |  | 20. AUTOPSY?                                                        |  |         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |        |                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                            |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                |                                         |  |                                                                     |  |         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |        |                   | P.M. 19                                                                                                 |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                        |  |        |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             |  |                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |                |                                         |  |                                                                     |  |         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |        |                   |                                                                                                         |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |  |        |                   | TITLE (SPECIFY)                                                                                         |  |                                    |  | DATE SIGNED                                                                                                                                              |                |                                         |  |                                                                     |  |         |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |        |                   | Assistant                                                                                               |  |                                    |  | 6/12/79                                                                                                                                                  |                |                                         |  |                                                                     |  |         |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |  |        |                   | ADDRESS                                                                                                 |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |        |                   | 111 Penn St. Balto., MD.                                                                                |  |                                    |  |                                                                                                                                                          |                |                                         |  |                                                                     |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              |  |        |                   | 23b. DATE                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                                                                                                                                          |                | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |                                                                     |  |         |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |        |                   | 6/15/79                                                                                                 |  | Arbutus Mem. Pk.                   |  |                                                                                                                                                          |                | Arbutus, Md.                            |  |                                                                     |  |         |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                              |  |        |                   |                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR      |  |                                                                                                                                                          |                | 25b. REGISTRAR'S SIGNATURE              |  |                                                                     |  |         |  |
| Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                                                         |  |        |                   |                                                                                                         |  | 1101 E. North Ave.                 |  |                                                                                                                                                          |                | JUN 15 1979                             |  |                                                                     |  |         |  |

MEDICAL CERTIFICATION

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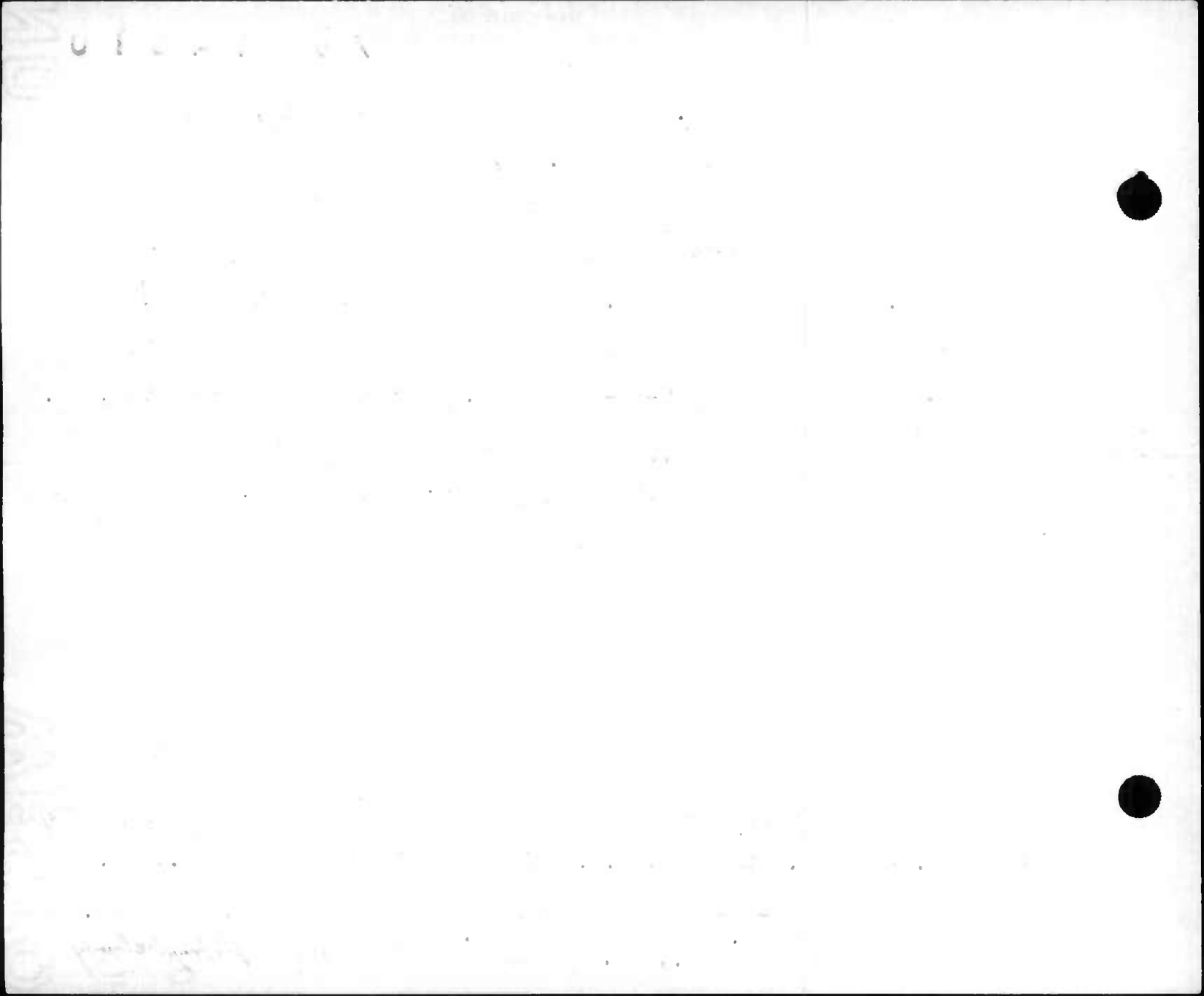
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            | 79 14510                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | REG. NO.                                                                                                                                   |                                                                     |                                                                                                                                                            |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Martha D. PAATSCH</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |                                                                     |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 22, 1979</b> |                                                                                                 |                                                                                      | 2b. HOUR<br><b>1:30 P.M.</b>                                                                                                               |                                                                                                                            |                                           |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>White</b>                                                                                                                     |                                                                     | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 11, 1889</b>                                                                                                     |                                                          | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                                |                                                                                      | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                                                |                                                                                                                            | 8 UNDER 24 HRS<br>HOURS MIN<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                     |                                                                                                                                                            |                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                       |                                                                                                                            |                                           |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                               |                                                                     | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                         |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS<br><b>Seton Hill Manor,</b>                                                                                            |                                                                                                                            |                                           |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Fred Tubesing</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |                                                                     | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nellie Vizay</b>                                                                                           |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>389-09-0677</b>                                                                                             |                                                                     | 17 INFORMANT ADDRESS<br><b>Mrs. Patricia Kanz Rockville, Md.</b>                                                                                           |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>410- Acute myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arteriosclerotic cardiovascular disease many yrs.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b> |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                            |                                                          |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                            |                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                  |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-22-79</b> to <b>6-22-79</b> , that (I) (we) last saw the deceased alive on <b>6-22-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                             |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 22b. SIGNATURE<br><b>Jamie Punzalan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          | DEGREE                                                                                          |                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>6-22-79</b>        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Jamie M. Punzalan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          | 22e. ADDRESS<br><b>1210 Temfield Road Balto., Md.</b>                                           |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            | 23b. DATE<br><b>6-23-79</b>                                         |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>  |                                                                                                 |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                                           |                                                                                                                            |                                           |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                             |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. H. H. H.</b>                                                                                        |                                                                                                                            |                                           |  |
| 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |                                                                     |                                                                                                                                                            |                                                          |                                                                                                 |                                                                                      |                                                                                                                                            |                                                                                                                            |                                           |  |





FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

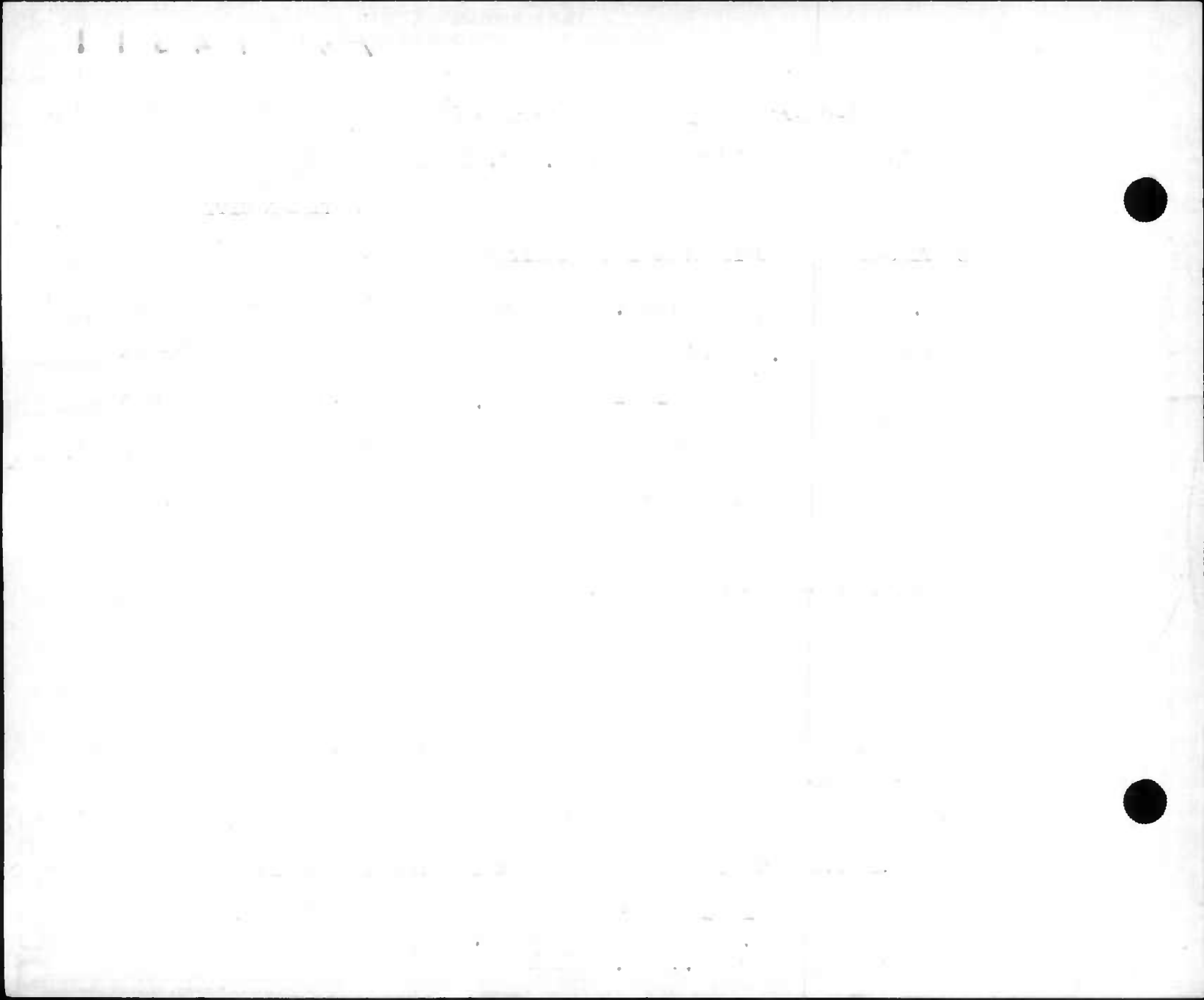
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|                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                |                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>CLARA L. PARENT                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                             | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>06 - 27 - 79 |                                                                                                | 2b HOUR<br>12.45 AM |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                         |  | 4 RACE<br>White                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 30, 1891                                             |                     |  |
| 6 AGE (IN YEARS (LAST BIRTHDAY))<br>88                                                                                                                                                                                                                                                  |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                                                                        |                                                    | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                             |                     |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                              |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                |                     |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                                        |                                                    | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |                     |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                                                                                                                                                                            |  | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                |                     |  |
| 13b COUNTY<br>Balto.                                                                                                                                                                                                                                                                    |  | 13c CITY OR TOWN<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |  |
| 13e STREET ADDRESS<br>3915 Beech Avenue                                                                                                                                                                                                                                                 |  | 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas T. O'Hearne                                                                                                                                                                                                                                                                                                                                                                 |                                                    |                                                                                                |                     |  |
| 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Barrett                                                                                                                                                                                                                            |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                |                     |  |
| 16b SOCIAL SECURITY NO.<br>214-74-7319                                                                                                                                                                                                                                                  |  | 17 INFORMANT<br>Mr. Eugene Parent                                                                                                                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                |                     |  |
| 18 ADDRESS<br>Same                                                                                                                                                                                                                                                                      |  | 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE 15 YRS</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CEREBRAL ATHEROSCLEROSIS</u><br>3 YRS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                    |                                                                                                |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>ANEMIA) &amp; X OF PROGRESSIVE WT LOSS</u>                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                |                     |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                             |                                                    | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                     |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                               |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |                                                    |                                                                                                |                     |  |
| 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                               |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                               |                                                    |                                                                                                |                     |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                       |                                                    | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                     |  |
| 22a I certify that (this hospital) attended the deceased from 6-18 19 77 to 6-27 19 79, that (we) last saw the deceased alive on 6-27 19 77, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                |                     |  |
| 22b SIGNATURE<br>Dennis J. Chodnicki MD                                                                                                                                                                                                                                                 |  | DEGREE<br>M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |                                                    | 22c DATE SIGNED<br>6-27-79                                                                     |                     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DENNIS J. CHODNICKI                                                                                                                                                                                                                             |  | 22e ADDRESS<br>UNION MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                                |                     |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                   |  | 23b DATE<br>6-30-79                                                                                                                                                                                                                                                                                                                                                                                                         |                                                    | 23c NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven                                            |                     |  |
| 23d LOCATION<br>CITY OR TOWN<br>Lewiston                                                                                                                                                                                                                                                |  | 23e COUNTY<br>New York                                                                                                                                                                                                                                                                                                                                                                                                      |                                                    | 23f STATE<br>New York                                                                          |                     |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212                                                                                                                                                                                          |  | 25a DATE REC'D. BY REG. CLERK<br>JUN 29 1979                                                                                                                                                                                                                                                                                                                                                                                |                                                    |                                                                                                |                     |  |
| 25b REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                |                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 5 1 2

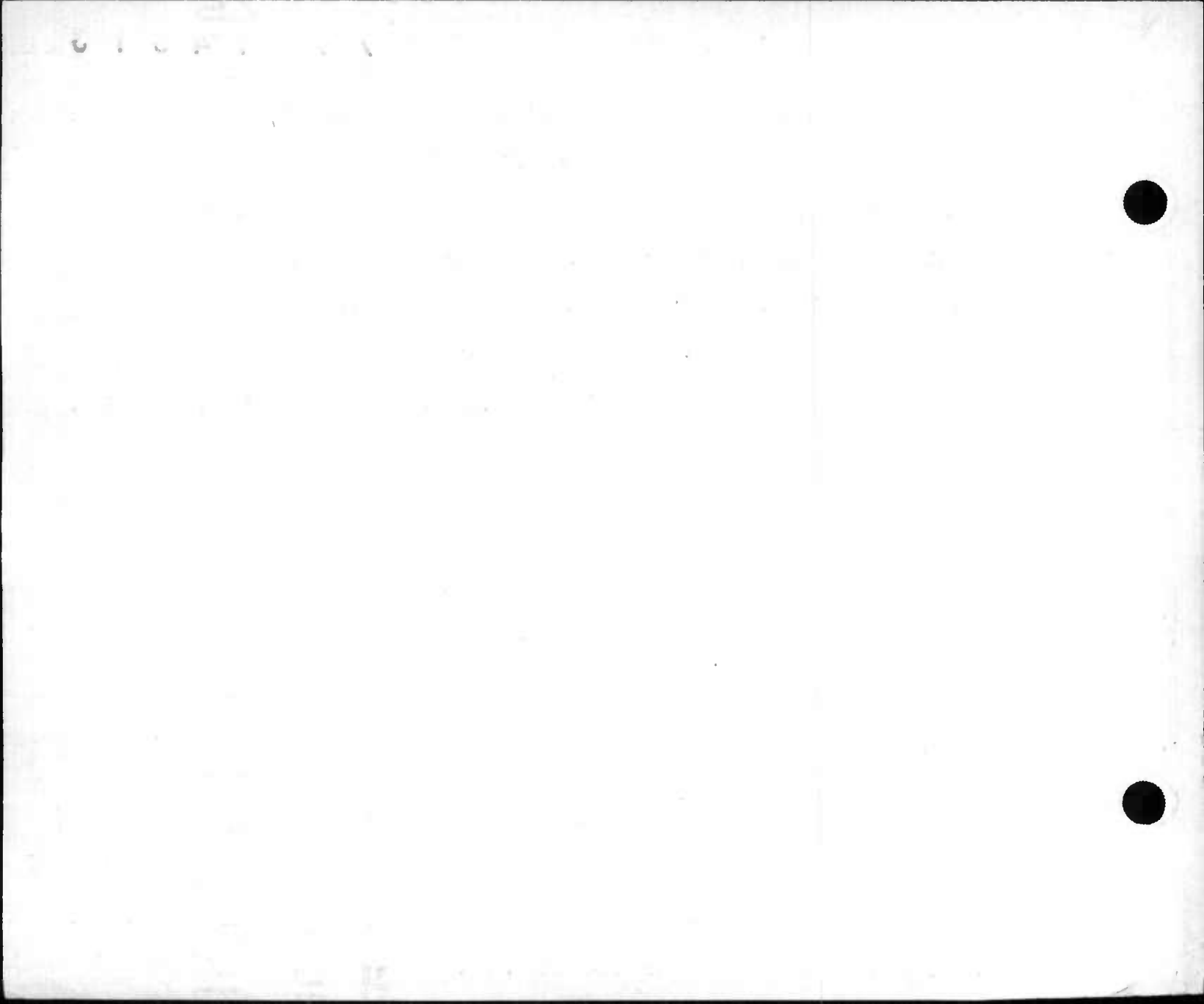
|                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                        |  |                                                                                                                                                         |  |                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                      |        | FIRST MIDDLE LAST                                                                                      |  | 2a DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  | 2b HOUR                                                       |  |
| Josephine                                                                                                                                                                                                                                                                                                                                                                               |        | Parker                                                                                                 |  | 6/28/79                                                                                                                                                 |  | 12:45 P                                                       |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                   | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR                                                                         |  | 6 AGE (IN YEARS (LAST BIRTHDAY))                                                                                                                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                |  |
| F                                                                                                                                                                                                                                                                                                                                                                                       | B      | 1 23 1886                                                                                              |  | 93                                                                                                                                                      |  |                                                               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                |        | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Calvert CO. Md.                                                                                                                                                                                                                                                                                                                                                                         |        | U.S.A.                                                                                                 |  |                                                                                                                                                         |  | Baltimore City MD.                                            |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                               |        | Midtown Home                                                                                           |  | Domestic Work                                                                                                                                           |  | Pvt. Family                                                   |  |
| 13a USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                              |        | 13b CITY OR TOWN                                                                                       |  | 13c INSIDE CITY LIMITS?                                                                                                                                 |  | 13d STREET ADDRESS                                            |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                |        | Baltimore                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                     |  | 808 St. Paul St.                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                      |        | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                              |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b SOCIAL SECURITY NO.                                       |  |
| Benson C. Johnson                                                                                                                                                                                                                                                                                                                                                                       |        | Julia A. Wallace                                                                                       |  | NO                                                                                                                                                      |  | 214 20 1637 D                                                 |  |
| 17 INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                    |        | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                            |  |                                                               |  |
| Mrs. Natalie Ennis 2530 Druid Hill                                                                                                                                                                                                                                                                                                                                                      |        | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ac Myocardial Infarction</u>                        |  |                                                                                                                                                         |  |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |        | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u>                                            |  |                                                                                                                                                         |  |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |        | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Breast</u>                                          |  |                                                                                                                                                         |  |                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                     |        |                                                                                                        |  |                                                                                                                                                         |  |                                                               |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 20a AUTOPSY?                                                                                                                                            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |        | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |        | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                               |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                 |        | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                        |  |                                                                                                                                                         |  |                                                               |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> 19 <u>71</u> to <u>Jan 28</u> 19 <u>79</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>Jun 28</u> 19 <u>79</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death. |        |                                                                                                        |  |                                                                                                                                                         |  |                                                               |  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                                                                                           |        | DEGREE                                                                                                 |  | 22c DATE SIGNED                                                                                                                                         |  |                                                               |  |
| <u>Herbert E. Nutter</u>                                                                                                                                                                                                                                                                                                                                                                |        | MD                                                                                                     |  |                                                                                                                                                         |  |                                                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                    |        | 22e ADDRESS                                                                                            |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |                                                               |  |
| APPLEFELD                                                                                                                                                                                                                                                                                                                                                                               |        | 6615 Kirkstone Rd.                                                                                     |  |                                                                                                                                                         |  |                                                               |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                |        | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                  |        | July 3, 79                                                                                             |  | Brooks United Meth                                                                                                                                      |  | Calvert County Md.                                            |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                |        | ADDRESS                                                                                                |  | 25a DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b REGISTRAR'S SIGNATURE                                     |  |
| Herbert E. Nutter                                                                                                                                                                                                                                                                                                                                                                       |        | 3035 W. North Ave.                                                                                     |  | JUL 6 1979                                                                                                                                              |  | <u>Herbert E. Nutter</u>                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        | 7 9 1 4 5 1 3                                                                 |  |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--|-----------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                                            | CERTIFICATE OF DEATH                                                                                                                                    |                                                                               |                                                                                         |                                                                                  | REG. NO.                                                                                                                                   |                                                                                                                        |                                                                               |  |                 |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MADELINE PARKER</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               | 2a DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 10, 1979</b>                                 |                                                                                  |                                                                                                                                            |                                                                                                                        | 2b HOUR<br><b>02:50PM</b>                                                     |  |                 |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>Negro</b>                                                                                                                      |                                                                            | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Oct 07 1914</b>                                                                                                    |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                        |                                                                                  | 7a UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>                                                                                                  |                                                                                                                        | 7b UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>                                     |  |                 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                    |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |                                                                            | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                        |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                            |                                                                                                                                                         |                                                                               | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dmestic</b>          |                                                                                  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                                           |                                                                                                                        |                                                                               |  |                 |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |  | 13b COUNTY<br><b>Calvert</b>                                                                                                                |                                                                            | 13c CITY OR TOWN<br><b>Prince Frederick</b>                                                                                                             |                                                                               | 13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                  | 13e STREET ADDRESS<br><b>Rt. 1 Box 61</b>                                                                                                  |                                                                                                                        |                                                                               |  |                 |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>George Eagans</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |                                                                            | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Katie Rumble</b>                                                                                        |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                  |  | 16b SOCIAL SECURITY NO<br><b>212 20-2612</b>                                                                                                |                                                                            | 17 INFORMANT ADDRESS<br><b>Bernice O. Sewell Box 17 Pr. Frederick, Md.</b>                                                                              |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b>                                                                                                                                                                                                          |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 HOURS</b>                |  |                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><b>4440</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        | DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL FAILURE / ACIDOSIS</b> |  | <b>10 HOURS</b> |
|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        | DUE TO, OR AS A CONSEQUENCE OF (c) <b>LOWER EXTREMITY ISCHEMIA</b>            |  | <b>4 DAYS</b>   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ATHEROSCLEROSIS OF ABDOMINAL AORTA</b>                                                                                                                                                                                |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 19a DATE OF OPERATION<br><b>6-9-79</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AORTIC OCCLUSION</b> |                                                                                                                                                         |                                                                               |                                                                                         | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                               |  |                 |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  |                                                                                                                                             | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>              |                                                                                                                                                         | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |  |                                                                                                                                             | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |                                                                                                                                                         | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6-9-79</b> 19 <b>79</b> to <b>6-10</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-10-79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               |                                                                                         |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 22b SIGNATURE<br><b>R. KATCH</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               | DEGREE<br><b>MD.</b>                                                                    |                                                                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                        | 22c DATE SIGNED<br><b>6-10-79</b>                                             |  |                 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. KATCH</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               | 22e ADDRESS<br><b>601 N. BROADWAY, BALTO MD 21205</b>                                   |                                                                                  |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             | 23b DATE<br><b>June 14-79</b>                                              |                                                                                                                                                         | 23c NAME OF CEMETERY OR CREMATORY<br><b>Browns Cem.</b>                       |                                                                                         | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Port Republic Calvert Md.</b>       |                                                                                                                                            |                                                                                                                        |                                                                               |  |                 |
| 24 FUNERAL DIRECTOR NAME<br><b>Spencer E. Sewell</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                            |                                                                                                                                                         |                                                                               | ADDRESS<br><b>Prince Frederick, Md.</b>                                                 |                                                                                  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 13 1978</b>                                                                                         |                                                                                                                        | 25b REGISTRAR'S SIGNATURE<br><b>Henry M. Bandy</b>                            |  |                 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 14514

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                          |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ERNEST A. PATTERSON</b>                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 11/18/79</b>                                                                                                    |  | 2b. HOUR<br><b>4<sup>15</sup> PM</b>                                                                                    |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>CAU.</b>                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 - 3 - 1914</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>65</b>                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY of MD. HOSP</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>                                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MD BALTO. BALTO.</b>                                                                                                                                                                                                                                                |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br><b>2 COOLBREEZE COURT</b>                                                                                                         |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MERLE PATTERSON</b>                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>A. CATHERINE</b>                                                                       |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO. <b>721-18-0478</b>                                                                                             |  | 17. INFORMANT ADDRESS<br><b>Mrs. Evelyn Patterson - 2 Coolbreeze Ct.</b>                                                                                 |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septic Shock</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUL PNEUMONIA (ASPIRATION)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <b>CAT cell CA Metastatic to Brain</b> |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/10</b> 19 <b>79</b> , to <b>6/18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Steven M Steinberg</b>                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br><b>MD</b>                                                                                                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN STEINBERG</b>                                                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br><b>UNIV of MD. HOSP</b>                                                                                                 |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>6-22-79</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILLS Cem.</b>                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b>                                                           |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Gertrude Miller Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>7527 Hayford Rd</b>                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 21 1979</b>                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                                                                   |  |

BP \_\_\_\_\_

11.11.11





Info added, G532 6/25/79 hal

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 14515

|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                               |                                                                                                                                                            |                                                                                             |                                                                               |                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY B. PATTERSON</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                               |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6-19-79</b>                                          |                                                                               | 2b. HOUR<br><b>6:50 AM</b>                                                                                             |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br><b>Black</b>                                                                                                                        | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>5 30 00</b>                                                                                                           |                                                                                             | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>79 71 YRS.</b>     |                                                                                                                        |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>                                                                                                                                                                                                                                                                                                                                       | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                 |                                                                                                                        |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                    | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Medical Center</b> |                                                                                                                                                            | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                               | 12b KIND OF BUSINESS OR INDUSTRY                                                                                       |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                              | 13b COUNTY<br><b>- -</b>                                                                                                                      | 13c CITY OR TOWN<br><b>Balto.</b>                                                                                                                          | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>1025 N. Bentalou St.</b>                             |                                                                                                                        |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine Roger</b>                                                                                        |                                                                                             | 16 ADDRESS<br><b>Raymond Smith 1025 Bentalou St.</b>                          |                                                                                                                        |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                               | 16b SOCIAL SECURITY NO.<br><b>218-03-8487A</b>                                                                                                             |                                                                                             | 17 INFORMANT<br><b>Raymond Smith</b>                                          |                                                                                                                        |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASCVD &amp; Brain Damage</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes - Etiology Undetermined</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                                               |                                                                                                                                                            |                                                                                             |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b><br><b>6 months</b>                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                           |                                                                                                                                               |                                                                                                                                                            |                                                                                             |                                                                               |                                                                                                                        |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                               | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                             | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |                                                                                                                                               | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |                                                                                             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                        |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                      |                                                                                                                                               | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                             | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                                                        |
| 22a I certify that (I) (this hospital) attended the deceased from <b>May 1979</b> to <b>June 1979</b> , that (I) (we) last saw the deceased alive on <b>June 18 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                          |                                                                                                                                               |                                                                                                                                                            |                                                                                             |                                                                               |                                                                                                                        |
| 22b SIGNATURE<br><b>Paul Schenfeld</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                               | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                                             | 22c DATE SIGNED<br><b>6/19/79</b>                                             |                                                                                                                        |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Schenfeld</b>                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               | 22e ADDRESS<br><b>1406 Crain Highway Glen Burnie 21061</b>                                                                                                 |                                                                                             |                                                                               |                                                                                                                        |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial Removal</b>                                                                                                                                                                                                                                                                                                                            | 23b DATE<br><b>6/19/79</b>                                                                                                                    | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>                                                                                                    |                                                                                             | 23d LOCATION CITY OR TOWN<br><b>Balto.</b>                                    | STATE<br><b>Maryland</b>                                                                                               |
| 24 FUNERAL DIRECTOR NAME<br><b>Charles Glover F.H. Anatomy Board</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | ADDRESS<br><b>4204 Ridgewood Balto., Md.</b>                                                                                                               |                                                                                             | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                            | 25b REGISTRAR'S SIGNATURE<br><b>Patrick McCreedy</b>                                                                   |

21241 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 1 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                   |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                    |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PEARSON, LINA                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-3-79                                 |                                                                                                 | 2b. HOUR<br>5:10 PM                                                |                                                                                                                            |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>B                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07-14-02                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                    |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY Balto. MD.                       |                                                                                                 |                                                                    |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                             |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                |                                                                                                                                   | 13b. COUNTY<br>Balto.                                                                                                                                       | 13c. CITY OR TOWN<br>Balto.                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>119 N. Mount Street                         |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jack McKive                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Nealie                                                                                                           |                                                                               |                                                                                                 |                                                                    |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>-                                                                                                                               | 17. INFORMANT<br>ADDRESS<br>Nina Ringgold 4712 Parmelee Rd.                   |                                                                                                 |                                                                    |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Possibile Pulmonary Embolus</u><br>4592<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Dehydration &amp; Hypokalemia</u> |                                                                                                                                   |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                              |                                                                                                                                   |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                    |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                         |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                    |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-2-</u> 19 <u>79</u> , to <u>6-3-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-3-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                     |                                                                                                                                   |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                    |                                                                                                                            |
| 22b. SIGNATURE<br><u>Harold K. Chittys MD</u>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                   |                                                                                                                                                             |                                                                               | 22c. DATE SIGNED<br>6-3-79                                                                      |                                                                    | 22d. DEGREE<br>MD                                                                                                          |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                   |                                                                                                                                                             |                                                                               | 22f. ADDRESS                                                                                    |                                                                    |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                   | 23b. DATE<br>6/7/79                                                                                                                                         |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Cameron Gr. Ch. Cem.                                      |                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Broadway, N.C.                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                   |                                                                                                                                                             |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1979                                                     |                                                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Rickey McNeely</u>                                                                        |

• 1 2 3 4 5 6 7 8



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

79

REG. NO.

14517

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            |                                                                                                                                   |                                                                                  |                                                                                                |                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES A. PEGELOW</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                                                                   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 5 79</b>                              |                                                                                                | 2b HOUR<br><b>6:05 PM</b>                                                                                                 |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                | 4 RACE<br><b>White</b>                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/27/1907</b>                                                                             | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                  |                                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>                                                                                                                                                                                                                                                                                                                       | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               | 8 MARRIED <input type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |                                                                                                |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                        | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                                                                                   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Barber</b> |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>                                                                       |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                            | 13b COUNTY<br><b>Balto.</b>                                                                                                       | 13c CITY OR TOWN<br><b>Dundalk</b>                                               | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS<br><b>119 Baltimore Ave. 21222</b>                                                                     |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John A. Pegelow</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola Wyckloff</b>                                                             |                                                                                  |                                                                                                |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>1923-25</b>                                                                    | 16c SOCIAL SECURITY NO<br><b>219.05.0708</b>                                                                                      | 17 INFORMANT ADDRESS<br><b>Helen E. Fletcher--Same as 13e</b>                    |                                                                                                |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4149 Ventricular Fibrillation</b> minutes<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ischemic H.D.</b> years<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                                            |                                                                                                                                   |                                                                                  |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                  |                                                                                                                                            |                                                                                                                                   |                                                                                  |                                                                                                |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                                                  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |                                                                                                                                            | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                  |                                                                                  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                       |                                                                                                                                            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                                                  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/5/79</b> 19 <b>78</b> to <b>6/5</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/5/79</b> 19 <b>78</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |                                                                                                                                            |                                                                                                                                   |                                                                                  |                                                                                                |                                                                                                                           |
| 22b SIGNATURE<br><b>F.M. DUGAN</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            | DEGREE<br><b>MD</b>                                                                                                               |                                                                                  | 22c DATE SIGNED<br><b>6/5/79</b>                                                               |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F.M. DUGAN</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            | 22e ADDRESS<br><b>15 E Biddle St Baltimore Md</b>                                                                                 |                                                                                  |                                                                                                |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                        | 23b DATE<br><b>6/8/1979</b>                                                                                                                | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                     |                                                                                  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | ADDRESS<br><b>Inc Dundalk, Md.</b>                                                                                                |                                                                                  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                             | 25b REGISTRAR'S SIGNATURE<br><b>Robert A. Bradley</b>                                                                     |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1124. 11

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  | 9 1 4 5 1 8                       |     |                                              |          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-----------------------------------|-----|----------------------------------------------|----------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                           |  | REG. NO.                                                                                               |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                 |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                                       |  | 2a. DATE OF DEATH                                                   |  | MONTH                             | DAY | YEAR                                         | 2b. HOUR |
|                                                                                                                                                                                                                                                                                                                  |  | ESTEBAN                                                                                                |  | (MMI)                                                                                                                                                    |  | PEREDA                                                                                                                                     |  | 6                                                                   |  | 16                                | 79  | 10:04P <sub>M</sub>                          |          |
| 3. SEX                                                                                                                                                                                                                                                                                                           |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  |                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                   |     | IF UNDER 24 HRS                              |          |
| Male                                                                                                                                                                                                                                                                                                             |  | White                                                                                                  |  | Oct. 18, 1898                                                                                                                                            |  |                                                                                                                                            |  | 80                                                                  |  | MONTHS                            |     | DAYS                                         |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                                            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |     |                                              |          |
| Spain                                                                                                                                                                                                                                                                                                            |  | U. S. A.                                                                                               |  |                                                                                                                                                          |  |                                                                                                                                            |  | Baltimore City,                                                     |  |                                   |     | MD.                                          |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |  |                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |     |                                              |          |
| Baltimore                                                                                                                                                                                                                                                                                                        |  | Church Hospital Corporation                                                                            |  |                                                                                                                                                          |  | Seaman                                                                                                                                     |  |                                                                     |  | Seafarer                          |     |                                              |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                          |  | 13a. STATE                                                                                             |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                                                                                          |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS               |     |                                              |          |
| Maryland                                                                                                                                                                                                                                                                                                         |  | ---                                                                                                    |  | ---                                                                                                                                                      |  | Baltimore                                                                                                                                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1928 Fleet Street                 |     |                                              |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| FIRST                                                                                                                                                                                                                                                                                                            |  | MIDDLE                                                                                                 |  | LAST                                                                                                                                                     |  | FIRST                                                                                                                                      |  | MIDDLE                                                              |  | LAST                              |     |                                              |          |
| Unknown                                                                                                                                                                                                                                                                                                          |  | Unknown                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| No                                                                                                                                                                                                                                                                                                               |  | 720-14-6619                                                                                            |  | Simon Garayoa - 608 S. Kenwood Ave. #21224                                                                                                               |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| 5789 IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL BLEEDING                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| (c)                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| SEVERE METABOLIC ACIDOSIS                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                   |     |                                              |          |
|                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                   |     |                                              |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
|                                                                                                                                                                                                                                                                                                                  |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
|                                                                                                                                                                                                                                                                                                                  |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                            |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                |  |                                                                                                        |  | STREET                                                                                                                                                   |  |                                                                                                                                            |  | CITY OR TOWN COUNTY STATE                                           |  |                                   |     |                                              |          |
| 22a. I certify that (this hospital) attended the deceased from JUNE 16, 1979, to JUNE 16, 1979, that (we) last saw the deceased alive on JUNE 16, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | 22c. DATE SIGNED                                                                                                                           |  |                                                                     |  |                                   |     |                                              |          |
|                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                     |  | 6/16/79.                          |     |                                              |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| J. K. SHETTY                                                                                                                                                                                                                                                                                                     |  | Church Hosp Corporation                                                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                        |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                                                                                              |  | COUNTY STATE                                                        |  |                                   |     |                                              |          |
| Burial                                                                                                                                                                                                                                                                                                           |  | June 20, 1978                                                                                          |  | St. Stanislaus                                                                                                                                           |  | Baltimore City,                                                                                                                            |  | Maryland                                                            |  |                                   |     |                                              |          |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  |                                                                                                                                                          |  | 25b. SIGNATURE                                                                                                                             |  |                                                                     |  |                                   |     |                                              |          |
| NAME                                                                                                                                                                                                                                                                                                             |  | ADDRESS                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                                   |     |                                              |          |
| GEORGE A. WEBER & Sons Inc.                                                                                                                                                                                                                                                                                      |  | 765 S. Ann St.                                                                                         |  |                                                                                                                                                          |  | JUN 19 1979                                                                                                                                |  |                                                                     |  |                                   |     |                                              |          |

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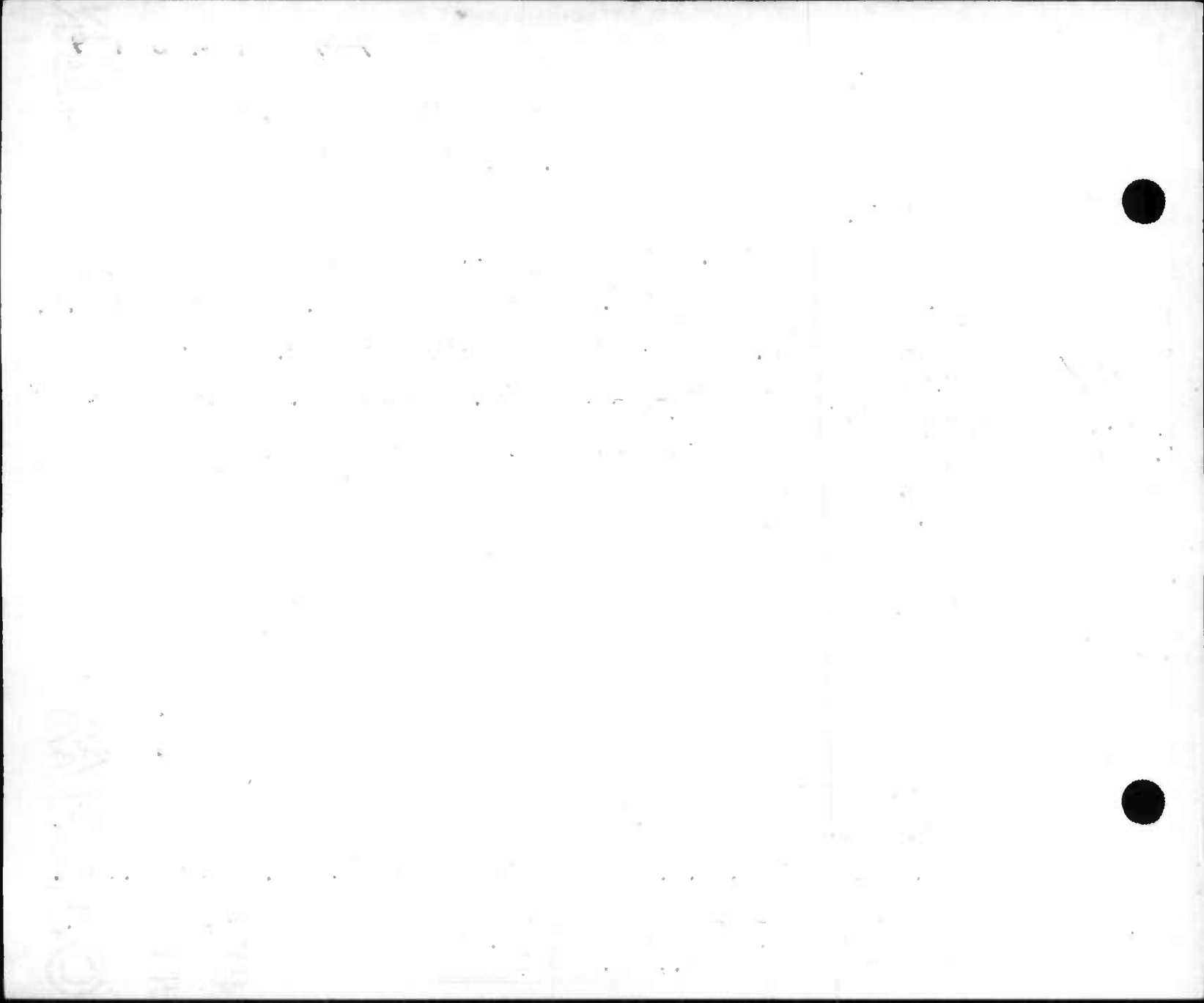


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  |                                                                                                                                                            |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                          |  | 7-9                                                                                                                               |  | 14519                                                                                                                                                      |                                                  | REG. NO.                                                                                                                                   |  |                                                                                                                        |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Eben Francis PERKINS III                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br>JUNE 17, 1979 |                                                                                                                                            |  | 2b HOUR<br>2 P M                                                                                                       |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br>White                                                                                                                   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Feb. 23, 1902                                                                                                            |                                                  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                                                                                   |  | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                                   |  |                                                                                                                        |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>501 W. University Pkwy. |  |                                                                                                                                                            |                                                  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney                                                                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Law                                                                                |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Md.                                                                                                                                                                                                                                                                                                        |  | 13b COUNTY<br>Balto.                                                                                                              |  | 13c CITY OR TOWN<br>Balto.                                                                                                                                 |                                                  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                |  | 13e STREET ADDRESS<br>501 W. University Pkwy. # 2E                                                                     |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Clarence W. Perkins                                                                                                                                                                                                                                                                                                                                                       |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth D. Owens                                                                   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                         |                                                  | 16b SOCIAL SECURITY NO<br>214-38-2719                                                                                                      |  | 17 INFORMANT ADDRESS<br>Mrs. Charlotte H. Perkins Same                                                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma - probably Pancreas<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                   |  |                                                                                                                                                            |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  |                                                                                                                                                            |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                            |                                                  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                               |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                         |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
| 22a I certify that (1) (this hospital) attended the deceased from 19 75 to 19 79, that (1) (we) last saw the deceased alive on 6/17/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.                                                                                                                 |  |                                                                                                                                   |  |                                                                                                                                                            |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
| 22b SIGNATURE<br>Walter B. Buck                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | DEGREE                                                                                                                                                     |                                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>6/18/79                                                                                             |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Walter Buck, M.D.                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  | 22e ADDRESS<br>33rd & Calvert Sts. Balto., Md.                                                                                                             |                                                  |                                                                                                                                            |  |                                                                                                                        |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                              |  | 23b DATE<br>6-20-79                                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY<br>Chester Cemetery                                                                                                      |                                                  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Chestertown, Md.                                                                                 |  |                                                                                                                        |  |
| 24 FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.<br>NAME 4905 York Road Balto., Md. 21212 ADDRESS                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                                                                                                |                                                  | 25b REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                   |  |                                                                                                                        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

M

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 2 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                              |                                                                                                                                                            |                                                                     |                                                                                |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Hattie C. Perry.                                                                                                                                                                                                                                                                                                                                  |                                                                                                                              |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>06 19 79<br>24 <sup>4</sup> M |                                                                                |                                                                                                                            |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                                              | 4 RACE<br>B                                                                                                                  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 25 03                                                                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75<br>YRS                         |                                                                                | 7b HOUR<br>24 <sup>4</sup> M                                                                                               |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                                        | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto., City MD.             |                                                                                |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hosp. |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                                                                                           |
| 13a STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                              |                                                                                                                                                            | 13b COUNTY<br>Balto.                                                |                                                                                | 13c CITY OR TOWN<br>Balto.                                                                                                 |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jack Crudup                                                                                                                                                                                                                                                                                                                                    |                                                                                                                              |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Hughes         |                                                                                |                                                                                                                            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                   |                                                                                                                              | 16b SOCIAL SECURITY NO<br>219-20-6526                                                                                                                      | 17 INFORMANT ADDRESS<br>Novella Perry 1620 Thomas Ave.              |                                                                                |                                                                                                                            |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Renal failure - chronic<br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Hypertensive Cardiovascular dis.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Anemia. |                                                                                                                              |                                                                                                                                                            |                                                                     |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Rectal bleeding.                                                                                                                                                                                                                                  |                                                                                                                              |                                                                                                                                                            |                                                                     |                                                                                |                                                                                                                            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                              | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                     | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                            |                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/19/79 to 6/19/79, that (I) (we) last saw the deceased alive on 6/19/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                   |                                                                                                                              |                                                                                                                                                            |                                                                     |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>H. J. Surgen.                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                              | DEGREE                                                                                                                                                     |                                                                     | 22c. DATE SIGNED<br>6/19/79.                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. J. Surgen.                                                                                                                                                                                                                                                                                                                                  |                                                                                                                              | 22e. ADDRESS<br>Provident Hospital.                                                                                                                        |                                                                     |                                                                                |                                                                                                                            |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                   |                                                                                                                              | 23b. DATE<br>6/22/79                                                                                                                                       |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Polk Chapel Cem.                         |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Franklin Co., N.C.                                                                                                                                                                                                                                                                                                                        |                                                                                                                              |                                                                                                                                                            |                                                                     |                                                                                |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                                           |                                                                                                                              | ADDRESS<br>1101 E. North Ave.                                                                                                                              |                                                                     | 25a DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                    |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                              | 25b. REGISTRAR'S SIGNATURE<br>L. J. H. H. H.                                                                                                               |                                                                     |                                                                                |                                                                                                                            |

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JUN 10 1970

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RECEIVED  
JUN 10 1970

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                 |  |                                                                                                                                      |                                                                  |                                                                      |  |
|---------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>THELMA NAOMI PERRY  |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/5/79<br>HOUR<br>7:35 AM |                                                                      |  |
| 3. SEX<br>Female                                                                |  | 4. RACE<br>Caucasian                                                                                                                 |                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 20, 1915                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63<br>YRS. MONTHS DAYS HRS. AM/PM |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesperson |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Avon Rep.                                                                                       |                                                                  |                                                                      |  |

|                                                                            |  |  |                                                              |  |  |                                                           |  |  |                                                                                                 |  |  |                                                   |  |  |
|----------------------------------------------------------------------------|--|--|--------------------------------------------------------------|--|--|-----------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------|--|--|
| 13a. STATE<br>Maryland                                                     |  |  | 13b. COUNTY<br>-                                             |  |  | 13c. CITY OR TOWN<br>Baltimore                            |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>4723 Chatford Avenue 21206 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Norwood                     |  |  |                                                              |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Iva Kopp |  |  |                                                                                                 |  |  |                                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>- |  |  | 17. INFORMANT<br>James W. Perry, Jr. (son) same as 13     |  |  | ADDRESS                                                                                         |  |  |                                                   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I: DEATH WAS CAUSED BY

|                                                                                                                                  |  |                                                   |
|----------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>                                                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>0 |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | 1 hr                                              |
| (b) <u>Septic Shock</u>                                                                                                          |  |                                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Probable Intestinal Cancer</u>                                                          |  | 1 yr                                              |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> 19 <u>79</u> to <u>6/5</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/5</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Nelson Lehman</u>                                                                                                                                                                                                                                                                                                              |  |                                                                        |  | DEGREE<br>M.D.                                                                       |  | 22c. DATE SIGNED<br>6/5/79                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NELSON LEHMAN, M.D.                                                                                                                                                                                                                                                                                        |  |                                                                        |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL                                              |  |                                                                                                                            |  |

|                                                        |  |                     |  |                                                         |  |                                                              |  |
|--------------------------------------------------------|--|---------------------|--|---------------------------------------------------------|--|--------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>Burial   |  | 23b. DATE<br>6/9/79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |
| 24. FUNERAL HOME<br>NAME<br>Schmuck Funeral Home, Inc. |  |                     |  | 25. DATE REC'D. BY REGISTRAR<br>JUN 5 1979              |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                   |                                                                                              |                                                                                                                         |                     |                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  | REG NO                                                                                                 |                                                                     | 9 1 4 5 2 2                                                                                                                                              |                                    |                                                                                   |                                                                                              |                                                                                                                         |                     |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        | FIRST MIDDLE LAST                                                   |                                                                                                                                                          |                                    | 2a. DATE OF DEATH MONTH DAY YEAR                                                  |                                                                                              |                                                                                                                         | 2b. HOUR            |                             |  |
| LANDER                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | PETERKIN                                                            |                                                                                                                                                          |                                    | 6 - 22 - 79                                                                       |                                                                                              |                                                                                                                         | 4:30 P.M.           |                             |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE                                                                                                |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)                                                   |                                                                                              | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |                     | IF UNDER 24 HRS. HOURS MIN. |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                            |  | BLACK                                                                                                  |                                                                     | 4 - 3 - 07                                                                                                                                               |                                    | 72 YRS.                                                                           |                                                                                              |                                                                                                                         |                     |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                                              |                                                                                              |                                                                                                                         |                     |                             |  |
| South Carolina                                                                                                                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                                                 |                                                                     |                                                                                                                                                          |                                    | BALTIMORE CITY MD.                                                                |                                                                                              |                                                                                                                         |                     |                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     |                                                                                                                                                          |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                     |                             |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Bon Secours Hosp.                                                                                      |                                                                     |                                                                                                                                                          |                                    | RETIRED                                                                           |                                                                                              | CHEF COOK                                                                                                               |                     |                             |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        | 13b. COUNTY                                                         |                                                                                                                                                          | 13c. CITY OR TOWN                  |                                                                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                         | 13e. STREET ADDRESS |                             |  |
| md.                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                     |                                                                                                                                                          | Baltimore                          |                                                                                   | YES                                                                                          |                                                                                                                         | 3701 Clifton Ave.   |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |                                                                                                                                                          |                                    |                                                                                   |                                                                                              |                                                                                                                         |                     |                             |  |
| Carey.                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | Peterkin                                                            |                                                                                                                                                          |                                    | maggie                                                                            |                                                                                              |                                                                                                                         | Breeding            |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        | 16b. SOCIAL SECURITY NO.                                            |                                                                                                                                                          |                                    | 17. INFORMANT                                                                     |                                                                                              |                                                                                                                         | ADDRESS             |                             |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 242-10-0846                                                         |                                                                                                                                                          |                                    | MRS. RUTH PETERKIN                                                                |                                                                                              |                                                                                                                         | 3701 CLIFTON AVENUE |                             |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA of the Pancreas</u><br><u>1579</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                   |                                                                                              |                                                                                                                         |                     |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                   |                                                                                              |                                                                                                                         |                     |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                     |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |  |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |                                                                                                                                                          |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                                                              |                                                                                                                         |                     |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                                                              |                                                                                                                         |                     |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>77</u> , to <u>6/22</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                   |                                                                                              |                                                                                                                         |                     |                             |  |
| 22b. SIGNATURE <u>Ruth Peterkin</u>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | DEGREE                                                                            |                                                                                              | 22c. DATE SIGNED <u>6/22</u>                                                                                            |                     |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ruth Peterkin</u>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | 22e. ADDRESS <u>Bon Secours Hosp.</u>                                             |                                                                                              |                                                                                                                         |                     |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 23b. DATE                                                           |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |                                                                                                                         |                     |                             |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 6/27/79                                                             |                                                                                                                                                          | ARBUTUS MEMORIAL PARK              |                                                                                   | BALTIMORE (BALTO.) MD.                                                                       |                                                                                                                         |                     |                             |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | 25a. DATE REC'D. BY REGISTRAR                                                     |                                                                                              | 25b. REGISTRAR'S SIGNATURE                                                                                              |                     |                             |  |
| LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | JUN 26 1979                                                                       |                                                                                              | <u>Henry McBrady</u>                                                                                                    |                     |                             |  |

14333



BALTIMORE CITY

\*

CHIEF COOK

WATKINS

3701 CLAYTON AVENUE

MRS. J. W. WATKINS

NO

RECEIVED 4/27/50  
BALTIMORE CITY  
CHIEF COOK

RECEIVED 4/27/50  
BALTIMORE CITY  
CHIEF COOK



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>WINFIELD PETERS                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 12 79                                      |                                                                                                 | 2b. HOUR<br>5:50A.M.                                                                                                       |
| 3 SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                             | 4 RACE<br>N                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 12 07                                                                                                              |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72<br>YRS                                                     |                                                                                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TEXAS                                                                                                                                                                                                                                                                                                                                                                                      | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MD.                                                      |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>BALT. CITY                                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RAILROAD PORTER |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>B+O Railcon                                                                           |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                             | 13b. COUNTY<br>—                                                                                                                                           | 13c. CITY OR TOWN<br>BALT                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>8 Charles Plaza                                                                                     |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William PETERS                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                             |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE CORTER                       |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>528-03-5581                                                                                                                    |                                                                                     | 17 INFORMANT<br>ADDRESS<br>MRS. MARY PETERS 8 Charles Plaza                                     |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Klebsiella Pneumonia<br>3320<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>b) PARKINSON'S DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week<br>7 years |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                    |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                               |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-25, 19 79, to 6-12, 19 79, that (I) (we) lost saw the deceased alive on 6-12, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                     |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>Stuart J. Jacobs MD                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             |                                                                                                                                                            |                                                                                     | 22c. DATE SIGNED<br>6-12-79                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JACOBS                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                             |                                                                                                                                                            |                                                                                     | 22e. ADDRESS<br>301 St. Paul Pl., BALT., MD. 21202                                              |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                             | 23b. DATE<br>JUNE 16, 79                                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARCTUS MEM. PARK                              |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY MD                                                          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HERBERT E. NUTTER 3035 W. North AVE.                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                             |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>R. J. H. H. H.                                                                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1 2 3 4 5 6 7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14524

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                            |                                                                                      |                                                                                      |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary V. Pettaway</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                             |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-30-79</b>                                |                                                                                      | 2b. HOUR<br><b>11:45 AM</b>                                     |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                | 4 RACE<br><b>Black</b>                                                                                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-26-23</b>                                                                                                       |                                                                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City MD.</b>                    |                                                                 |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital of Md</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                 |                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            |                                                                                      | 13e. STREET ADDRESS<br><b>1648 Ashburton St.</b>                                     |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie Roger Owens</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Owens</b>                                                                                      |                                                                                      |                                                                                      |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>224-26-6532</b>                                                                                              | 17 INFORMANT<br>ADDRESS<br><b>Annie M. M. Madden 2435 Lakewood</b>                                                                                         |                                                                                      |                                                                                      |                                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Sep. tic shock.</b><br><b>586-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Renal failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |                                                                                                                                             |                                                                                                                                                            |                                                                                      |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Renal failure, Diabetes, Arteriosclerosis.</b>                                                                                                                                                                                               |                                                                                                                                             |                                                                                                                                                            |                                                                                      |                                                                                      |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                          |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                        |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-15-79</b> , 19 <b>79</b> , to <b>6-30-79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-30-79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |                                                                                                                                             |                                                                                                                                                            |                                                                                      |                                                                                      |                                                                 |
| 22b. SIGNATURE<br><b>S. S. S. A. A. A.</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | DEGREE                                                                                                                                                     |                                                                                      | 22c. DATE SIGNED<br><b>6-30-79.</b>                                                  |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. S. S. A. A. A.</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                             | 22e. ADDRESS<br><b>Lutheran Hospital</b>                                                                                                                   |                                                                                      |                                                                                      |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                           | 23b. DATE<br><b>7-6-79</b>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>                                                                                                   |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, Md</b>                 |                                                                 |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Charles L. Glover</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             | ADDRESS<br><b>F.H. 4204 Ridgewood</b>                                                                                                                      |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                   |                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>—</b>                                                                                                                     |                                                                                      |                                                                                      |                                                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

426-181

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14525

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                          |  |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SAMUEL Pettigrew</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 10 79</b>                                                                                                    |  | 2b. HOUR<br><b>10:25 AM</b>                                                                     |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>BLACK</b>                                                                                                                                   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 14 93</b>                                             |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                      |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD                                                                                               |  |                                                                                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sonai Hospital</b>                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13a. STATE<br><b>MD</b>                                                                                                                                  |  |                                                                                                 |  |
| 13b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda Harris</b>                                                                                    |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><b>220-12-6860</b>                                                                                                           |  | 17. INFORMANT<br>ADDRESS<br><b>Dora Pettigrew same</b>                                          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>185-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>obstructive uropathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic prostate cancer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                          |  |                                                                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                             |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |                                                                                                 |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/10/79</b> to <b>6/1/79</b> , that (I) (we) last saw the deceased alive on <b>6/1/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.                                                                                                                               |  |                                                                                                                                                          |  |                                                                                                 |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br><b>MD</b>                                                                                                                                      |  | 22c. DATE SIGNED<br><b>6/10/79</b>                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James H. Pichler</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br><b>Sonai Hospital</b>                                                                                                                    |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>6-14-79</b>                                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 24 FUNERAL DIRECTOR<br>NAME<br><b>Vernon R. Bailey</b>                                                                                                   |  |                                                                                                 |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                         |  |                                                                                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

The figure consists of six sequential black and white micrographs arranged horizontally, showing the development of an embryo. From left to right: 1. A single, dark, rounded cell. 2. A cell with a more defined, slightly elongated shape. 3. A cell showing internal structure and a more complex, somewhat irregular shape. 4. A cell with a distinct, elongated, and segmented appearance, possibly representing a larval stage. 5. A cell with a more complex, segmented structure, showing clear internal divisions. 6. A cell with a highly complex, segmented structure, showing multiple internal divisions and a more elongated, worm-like shape.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FREED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14526

|                                                                                                                                                                                                      |         |                                                                                                                                                                                                      |        |                                                                                                                                                                                                      |                         |                                                                                                                                                                                                      |                 |                                                                                                                                                                                                      |                          |                                                                                                                                                                                                      |          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                  |         | FIRST                                                                                                                                                                                                | MIDDLE | LAST                                                                                                                                                                                                 | 2b. DATE KNOWN OF DEATH |                                                                                                                                                                                                      | ESTIMATED       | MONTH                                                                                                                                                                                                | DAY                      | YEAR                                                                                                                                                                                                 | 2d. HOUR |
| BETTY                                                                                                                                                                                                |         |                                                                                                                                                                                                      |        | PETTY                                                                                                                                                                                                | 6                       |                                                                                                                                                                                                      | 3               | 19                                                                                                                                                                                                   | 79                       |                                                                                                                                                                                                      |          |
| 3. SEX                                                                                                                                                                                               | 4. RACE | 5. DATE OF BIRTH                                                                                                                                                                                     |        | 6. AGE (IN YEARS)                                                                                                                                                                                    | IF UNDER 1 YR           |                                                                                                                                                                                                      | IF UNDER 24 HRS |                                                                                                                                                                                                      | 7c. DATE PRONOUNCED DEAD |                                                                                                                                                                                                      | 2d. HOUR |
| female                                                                                                                                                                                               | negro   | 10 4 14                                                                                                                                                                                              |        | 64 YRS.                                                                                                                                                                                              |                         |                                                                                                                                                                                                      |                 |                                                                                                                                                                                                      | 6 4 19 79                |                                                                                                                                                                                                      | 5:35     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                            |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                         |        | 8. MARRIED                                                                                                                                                                                           |                         | NEVER MARRIED                                                                                                                                                                                        |                 | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                 |                          |                                                                                                                                                                                                      |          |
| Ga.                                                                                                                                                                                                  |         | USA                                                                                                                                                                                                  |        | WIDOWED                                                                                                                                                                                              |                         | DIVORCED                                                                                                                                                                                             |                 | Baltimore City                                                                                                                                                                                       |                          | MD.                                                                                                                                                                                                  |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                            |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                                             |        |                                                                                                                                                                                                      |                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                        |                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                    |                          |                                                                                                                                                                                                      |          |
| Baltimore                                                                                                                                                                                            |         | 201 N. Broadway                                                                                                                                                                                      |        |                                                                                                                                                                                                      |                         |                                                                                                                                                                                                      |                 |                                                                                                                                                                                                      |                          |                                                                                                                                                                                                      |          |
| 13a. STATE                                                                                                                                                                                           |         | 13b. COUNTY                                                                                                                                                                                          |        | 13c. CITY OR TOWN                                                                                                                                                                                    |                         | 13d. INSIDE CITY LIMITS?                                                                                                                                                                             |                 | 13e. STREET ADDRESS                                                                                                                                                                                  |                          |                                                                                                                                                                                                      |          |
| MD.                                                                                                                                                                                                  |         |                                                                                                                                                                                                      |        | Balto.                                                                                                                                                                                               |                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                  |                 | 201 N. Broadway                                                                                                                                                                                      |                          |                                                                                                                                                                                                      |          |
| 14. FATHER'S NAME                                                                                                                                                                                    |         | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                         |                         | 16b. SOCIAL SECURITY NO.                                                                                                                                                                             |                 | 17. INFORMANT                                                                                                                                                                                        |                          | ADDRESS                                                                                                                                                                                              |          |
| Nimrod                                                                                                                                                                                               |         | Moena                                                                                                                                                                                                |        | No                                                                                                                                                                                                   |                         | 084-16-0947                                                                                                                                                                                          |                 | Lottie Williams                                                                                                                                                                                      |                          | 201 N. Broaway                                                                                                                                                                                       |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |        | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |                         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |                          | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |          |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |         | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |        | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |                         | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |                 | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |                          | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |          |
| IMMEDIATE CAUSE (a)                                                                                                                                                                                  |         | IMMEDIATE CAUSE (a)                                                                                                                                                                                  |        | IMMEDIATE CAUSE (a)                                                                                                                                                                                  |                         | IMMEDIATE CAUSE (a)                                                                                                                                                                                  |                 | IMMEDIATE CAUSE (a)                                                                                                                                                                                  |                          | IMMEDIATE CAUSE (a)                                                                                                                                                                                  |          |
| 4029                                                                                                                                                                                                 |         | 4029                                                                                                                                                                                                 |        | 4029                                                                                                                                                                                                 |                         | 4029                                                                                                                                                                                                 |                 | 4029                                                                                                                                                                                                 |                          | 4029                                                                                                                                                                                                 |          |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                        |         | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                        |        | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                        |                         | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                        |                 | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                        |                          | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                        |          |
| (b)                                                                                                                                                                                                  |         | (b)                                                                                                                                                                                                  |        | (b)                                                                                                                                                                                                  |                         | (b)                                                                                                                                                                                                  |                 | (b)                                                                                                                                                                                                  |                          | (b)                                                                                                                                                                                                  |          |
| (c)                                                                                                                                                                                                  |         | (c)                                                                                                                                                                                                  |        | (c)                                                                                                                                                                                                  |                         | (c)                                                                                                                                                                                                  |                 | (c)                                                                                                                                                                                                  |                          | (c)                                                                                                                                                                                                  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                   |         | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                   |        | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                   |                         | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                   |                 | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                   |                          | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                   |          |
| 19a. DATE OF OPERATION                                                                                                                                                                               |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |          |
|                                                                                                                                                                                                      |         |                                                                                                                                                                                                      |        |                                                                                                                                                                                                      |                         |                                                                                                                                                                                                      |                 |                                                                                                                                                                                                      |                          |                                                                                                                                                                                                      |          |
| 20. AUTOPSY?                                                                                                                                                                                         |         | 20. AUTOPSY?                                                                                                                                                                                         |        | 20. AUTOPSY?                                                                                                                                                                                         |                         | 20. AUTOPSY?                                                                                                                                                                                         |                 | 20. AUTOPSY?                                                                                                                                                                                         |                          | 20. AUTOPSY?                                                                                                                                                                                         |          |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                  |         | 21b. TIME OF INJURY                                                                                                                                                                                  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                        |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                        |                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                        |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                        |          |
|                                                                                                                                                                                                      |         | HOUR A.M. MONTH DAY YEAR                                                                                                                                                                             |        |                                                                                                                                                                                                      |                         |                                                                                                                                                                                                      |                 |                                                                                                                                                                                                      |                          |                                                                                                                                                                                                      |          |
|                                                                                                                                                                                                      |         | P.M. 19                                                                                                                                                                                              |        |                                                                                                                                                                                                      |                         |                                                                                                                                                                                                      |                 |                                                                                                                                                                                                      |                          |                                                                                                                                                                                                      |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                             |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |        | 21f. LOCATION                                                                                                                                                                                        |                         | 21f. LOCATION                                                                                                                                                                                        |                 | 21f. LOCATION                                                                                                                                                                                        |                          | 21f. LOCATION                                                                                                                                                                                        |          |
|                                                                                                                                                                                                      |         |                                                                                                                                                                                                      |        | CITY OR TOWN                                                                                                                                                                                         |                         | CITY OR TOWN                                                                                                                                                                                         |                 | CITY OR TOWN                                                                                                                                                                                         |                          | CITY OR TOWN                                                                                                                                                                                         |          |
|                                                                                                                                                                                                      |         |                                                                                                                                                                                                      |        | COUNTY                                                                                                                                                                                               |                         | COUNTY                                                                                                                                                                                               |                 | COUNTY                                                                                                                                                                                               |                          | COUNTY                                                                                                                                                                                               |          |
|                                                                                                                                                                                                      |         |                                                                                                                                                                                                      |        | STATE                                                                                                                                                                                                |                         | STATE                                                                                                                                                                                                |                 | STATE                                                                                                                                                                                                |                          | STATE                                                                                                                                                                                                |          |
| 22a. I certify that I took charge of the remains described above, held an                                                                                                                            |         | 22a. I certify that I took charge of the remains described above, held an                                                                                                                            |        | 22a. I certify that I took charge of the remains described above, held an                                                                                                                            |                         | 22a. I certify that I took charge of the remains described above, held an                                                                                                                            |                 | 22a. I certify that I took charge of the remains described above, held an                                                                                                                            |                          | 22a. I certify that I took charge of the remains described above, held an                                                                                                                            |          |
| death resulted from:                                                                                                                                                                                 |         | death resulted from:                                                                                                                                                                                 |        | death resulted from:                                                                                                                                                                                 |                         | death resulted from:                                                                                                                                                                                 |                 | death resulted from:                                                                                                                                                                                 |                          | death resulted from:                                                                                                                                                                                 |          |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                 | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                          | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |          |
| ACTUAL SIGNATURE                                                                                                                                                                                     |         | ACTUAL SIGNATURE                                                                                                                                                                                     |        | ACTUAL SIGNATURE                                                                                                                                                                                     |                         | ACTUAL SIGNATURE                                                                                                                                                                                     |                 | ACTUAL SIGNATURE                                                                                                                                                                                     |                          | ACTUAL SIGNATURE                                                                                                                                                                                     |          |
| Virginia L. Dolan                                                                                                                                                                                    |         | Virginia L. Dolan                                                                                                                                                                                    |        | Virginia L. Dolan                                                                                                                                                                                    |                         | Virginia L. Dolan                                                                                                                                                                                    |                 | Virginia L. Dolan                                                                                                                                                                                    |                          | Virginia L. Dolan                                                                                                                                                                                    |          |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |         | EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |        | EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |                         | EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |                 | EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |                          | EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |          |
| Virginia L. Dolan, M.D.                                                                                                                                                                              |         | Virginia L. Dolan, M.D.                                                                                                                                                                              |        | Virginia L. Dolan, M.D.                                                                                                                                                                              |                         | Virginia L. Dolan, M.D.                                                                                                                                                                              |                 | Virginia L. Dolan, M.D.                                                                                                                                                                              |                          | Virginia L. Dolan, M.D.                                                                                                                                                                              |          |
| TITLE (SPECIFY)                                                                                                                                                                                      |         | TITLE (SPECIFY)                                                                                                                                                                                      |        | TITLE (SPECIFY)                                                                                                                                                                                      |                         | TITLE (SPECIFY)                                                                                                                                                                                      |                 | TITLE (SPECIFY)                                                                                                                                                                                      |                          | TITLE (SPECIFY)                                                                                                                                                                                      |          |
| Assistant                                                                                                                                                                                            |         | Assistant                                                                                                                                                                                            |        | Assistant                                                                                                                                                                                            |                         | Assistant                                                                                                                                                                                            |                 | Assistant                                                                                                                                                                                            |                          | Assistant                                                                                                                                                                                            |          |
| DATE SIGNED                                                                                                                                                                                          |         | DATE SIGNED                                                                                                                                                                                          |        | DATE SIGNED                                                                                                                                                                                          |                         | DATE SIGNED                                                                                                                                                                                          |                 | DATE SIGNED                                                                                                                                                                                          |                          | DATE SIGNED                                                                                                                                                                                          |          |
| 6-5-79                                                                                                                                                                                               |         | 6-5-79                                                                                                                                                                                               |        | 6-5-79                                                                                                                                                                                               |                         | 6-5-79                                                                                                                                                                                               |                 | 6-5-79                                                                                                                                                                                               |                          | 6-5-79                                                                                                                                                                                               |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                            |         | 23b. DATE                                                                                                                                                                                            |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                   |                         | 23d. LOCATION                                                                                                                                                                                        |                 | 23e. REGISTRAR'S SIGNATURE                                                                                                                                                                           |                          | 23f. REGISTRAR'S SIGNATURE                                                                                                                                                                           |          |
| Burial                                                                                                                                                                                               |         | 6/9/79                                                                                                                                                                                               |        | King Memorial Pk.                                                                                                                                                                                    |                         | Baltimore Co., Md.                                                                                                                                                                                   |                 | Fistay nebrudy                                                                                                                                                                                       |                          | Fistay nebrudy                                                                                                                                                                                       |          |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                 |         | 24. FUNERAL DIRECTOR                                                                                                                                                                                 |        | 24. FUNERAL DIRECTOR                                                                                                                                                                                 |                         | 24. FUNERAL DIRECTOR                                                                                                                                                                                 |                 | 24. FUNERAL DIRECTOR                                                                                                                                                                                 |                          | 24. FUNERAL DIRECTOR                                                                                                                                                                                 |          |
| Wm C March F/H                                                                                                                                                                                       |         | Wm C March F/H                                                                                                                                                                                       |        | Wm C March F/H                                                                                                                                                                                       |                         | Wm C March F/H                                                                                                                                                                                       |                 | Wm C March F/H                                                                                                                                                                                       |                          | Wm C March F/H                                                                                                                                                                                       |          |
| ADDRESS                                                                                                                                                                                              |         | ADDRESS                                                                                                                                                                                              |        | ADDRESS                                                                                                                                                                                              |                         | ADDRESS                                                                                                                                                                                              |                 | ADDRESS                                                                                                                                                                                              |                          | ADDRESS                                                                                                                                                                                              |          |
| 1101 E. North Ave.                                                                                                                                                                                   |         | 1101 E. North Ave.                                                                                                                                                                                   |        | 1101 E. North Ave.                                                                                                                                                                                   |                         | 1101 E. North Ave.                                                                                                                                                                                   |                 | 1101 E. North Ave.                                                                                                                                                                                   |                          | 1101 E. North Ave.                                                                                                                                                                                   |          |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |         | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |                         | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |                 | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |                          | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |          |
| JUN 7 1979                                                                                                                                                                                           |         | JUN 7 1979                                                                                                                                                                                           |        | JUN 7 1979                                                                                                                                                                                           |                         | JUN 7 1979                                                                                                                                                                                           |                 | JUN 7 1979                                                                                                                                                                                           |                          | JUN 7 1979                                                                                                                                                                                           |          |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14527

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                          |  |                                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2a. DATE KNOWN OF DEATH                                                                                                        |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |  | 3. SEX                                                                                                                         |  | 4. RACE                                                                                                                                                  |  | 5. DATE OF BIRTH                                                                             |  |
| Mary Pfisterer                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Female                                                                                                                         |  | White                                                                                                                                                    |  | Jan. 25, 1888                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              |  | U.S.A.                                                                                                                         |  |                                                                                                                                                          |  | Baltimore City, MD.                                                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Baltimore City Hospital                                                                                                        |  | Telephone Operator                                                                                                                                       |  | Retired                                                                                      |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                    |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  | Baltimore                                                                                                                                                |  | 710 S. Conkling Street                                                                       |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                                                                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                       |  | 16b. SOCIAL SECURITY NO.                                                                     |  |
| Alphonse Pfisterer                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Mary Guttman                                                                                                                   |  | No                                                                                                                                                       |  | 212-01-9411                                                                                  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS                                                                                                                        |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |  |
| Catherine Celmer                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 710 S. Conkling Street                                                                                                         |  | PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease                                                                  |  |                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |  |                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |  |                                                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  | Nasal fracture from fall                                                                                                       |  | 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                          |  |                                                                                              |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR                                                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 3:10 P.M. 6 7 1979                                                                                                             |  | Subject fell                                                                                                                                             |  |                                                                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                    |  | 21f. LOCATION                                                                                                                                            |  | STATE                                                                                        |  |
| home                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 710 S. Conkling St., Baltimore                                                                                                 |  | Md.                                                                                                                                                      |  |                                                                                              |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. TITLE (SPECIFY)                                                                                                           |  | DATE SIGNED                                                                                                                                              |  |                                                                                              |  |
| ACTUAL SIGNATURE Virginia L. Dolan                                                                                                                                                                                                                                                                                                                                                                                                     |  | Assistant                                                                                                                      |  | 6/8/79                                                                                                                                                   |  |                                                                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS                                                                                                                        |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                |  | 23b. DATE                                                                                    |  |
| Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |  | 111 Penn Street                                                                                                                |  | Burial                                                                                                                                                   |  | 6-11-1979                                                                                    |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY                                                           |  |
| Lilly & Zeiler Inc.                                                                                                                                                                                                                                                                                                                                                                                                                    |  | JUN 11 1979                                                                                                                    |  | History McCreedy                                                                                                                                         |  | Sacred Heart of Jesus                                                                        |  |
| 23d. LOCATION (CITY OR TOWN)                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23e. COUNTY                                                                                                                    |  | 23f. STATE                                                                                                                                               |  |                                                                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Baltimore County                                                                                                               |  | Maryland                                                                                                                                                 |  |                                                                                              |  |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 2 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>GEORGE WILLIAM PHILLIPS                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>June 18, 1979                                 |                                                                                                | 2b HOUR<br>11:45 P.M.                                                                                                     |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br>White                                                                                                             | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>March 1, 1923                                                                                                         |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pittsburgh, Pa.                                                                                                                                                                                                                                                                                                                                                                              | 7b CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes E.R. |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Engineer |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br>Bendix Corp.                                                                          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                         |                                                                                                                             | 13b COUNTY<br>Baltimore                                                                                                                                    | 13c CITY OR TOWN<br>Catonsville                                                     | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS<br>1208 Westerlee Place 21228                                                                          |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George E. Phillips                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pauline Riggs                                                                                             |                                                                                     |                                                                                                |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                             | 16b SOCIAL SECURITY NO.<br>WW2 141-16-3989                                                                                                                 | 17 INFORMANT<br>ADDRESS<br>Twile R. Phillips, 1208 Westerlee Place                  |                                                                                                |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>515- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Fibrosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>10 yrs - |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Secondary Polychemia</u>                                                                                                                                                                                                                                                                           |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                             | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                  |                                                                                                                             | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                             | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> to <u>6-18</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6-15</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                                                    |                                                                                                                             |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                           |
| 22b SIGNATURE<br><u>J. Nelson McKay M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                        |                                                                                                                             |                                                                                                                                                            |                                                                                     | 22c DATE SIGNED<br>6-19-79                                                                     |                                                                                                                           |
| 23a PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. J. Nelson McKay                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             |                                                                                                                                                            |                                                                                     | 22a ADDRESS<br>1132 N. Rolling Rd, Baltimore, Md.                                              |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                             | 23b DATE<br>6/21/79                                                                                                                                        | 23c NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cemetery                           |                                                                                                | 23d LOCATION<br>CITY OR TOWN DORSEY, A.A. COUNTY STATE                                                                    |
| 24 FUNERAL DIRECTOR<br>NAME 1630 Edmondson Ave, Catonsville, Md.<br>Witzke Catonsville Funeral Home, P.A. 21228                                                                                                                                                                                                                                                                                                                          |                                                                                                                             |                                                                                                                                                            |                                                                                     | 25a DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                    |                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                             |                                                                                                                                                            |                                                                                     | 25b REGISTRAR'S SIGNATURE<br><u>H. H. H. H. H.</u>                                             |                                                                                                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                 |  |                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  | REG. NO. 14529                                                                                                      |  |                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|
| 1- REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                 |  |                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <sup>FIRST</sup> Maryetta <sup>MIDDLE</sup> (MARIATA) <sup>LAST</sup> PHILLIPS                                                                                                                                                                                                                                                                                                                        |  |                 |  |                                                                                                                                                    |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR           |  |                                                                                                                                                            | 2b. HOUR |                                                               |  |                                                                                                                     |  |                                   |  |
| 3 SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br>negro |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 10 36                                                                                                      |  | 6 AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>42 YRS.                                       |  | IF UNDER 1 YR<br>MONTHS DAYS                                                                                                                               |          | IF UNDER 24 HRS<br>HOURS MIN                                  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 4 19 79                                                             |  | 7d. HOUR<br>8:04 p                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia                                                                                                                                                                                                                                                                                                                                                                                     |  |                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                |  |                                                                                      |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          |                                                               |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                           |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>(car) front of 5209 Reisterstown Rd. |  |                                                                                      |  |                                                                                                                                                            |          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                                                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                               |  |                 |  |                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                 |  | 13b. COUNTY                                                                                                                                        |  | 13c. CITY OR TOWN<br>Baltimore                                                       |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                            |          | 13e. STREET ADDRESS<br>5242 St. Charles Ave.                  |  |                                                                                                                     |  |                                   |  |
| 14 FATHER'S NAME<br><sup>FIRST</sup> Walter <sup>MIDDLE</sup> Alridge <sup>LAST</sup>                                                                                                                                                                                                                                                                                                                                                    |  |                 |  |                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br><sup>FIRST</sup> Hanna <sup>MIDDLE</sup> <sup>LAST</sup> |  |                                                                                                                                                            |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                              |  |                 |  | 16b. SOCIAL SECURITY NO.<br>254-70-9051                                                                                                            |  |                                                                                      |  | 17 INFORMANT<br>ADDRESS<br>RANDY PHILLIPS 4114 W. Belvedere                                                                                                |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: Acute alcohol intoxication<br>IMMEDIATE CAUSE (a) <u>3050</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                              |  |                 |  |                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                        |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                 |  |                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                  |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                         |  |                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                              |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                |  |                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                        |  |                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                 |  |                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                                            |          |                                                               |  |                                                                                                                     |  |                                   |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                      |  |                 |  |                                                                                                                                                    |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                   |  |                                                                                                                                                            |          | DATE SIGNED 6-5-79                                            |  |                                                                                                                     |  |                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |                 |  |                                                                                                                                                    |  | ADDRESS<br>111 Penn St.                                                              |  |                                                                                                                                                            |          |                                                               |  |                                                                                                                     |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                      |  |                 |  | 23b. DATE<br>6/11/79                                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.                              |  |                                                                                                                                                            |          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |                                                                                                                     |  |                                   |  |
| 24 FUNERAL DIRECTOR<br>NAME Wm. C. March F/H                                                                                                                                                                                                                                                                                                                                                                                             |  |                 |  |                                                                                                                                                    |  | ADDRESS<br>1101 E. North Ave.                                                        |  |                                                                                                                                                            |          | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                                   |  |

92241



*Handwritten signature*

100-1079

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14530  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        |                                                                                                                                          |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mildred Pierce</b>                                                                                                                                                                                                                                                                                                                                                                               |                        |                                                                                                                                          | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>6 1 79</b> |                                                                                                                                                            |                                                                                                               | 2b. HOUR<br>M<br><b>10:15 a</b>                                                                 |                                                                                     |                                              |
| 3 SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 4 RACE<br><b>white</b> | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 18, 1902</b>                                                                                | 6 AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>76</b>                          | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                   | IF UNDER 24 HRS.                                                                                              | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 1 79</b>                                     |                                                                                     | 2d. HOUR<br>M<br><b>10:15 a</b>              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                        |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                         | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                 |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                             |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |                                                                         |                                                                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>waitress</b>                              |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>                              |                                              |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                |                        |                                                                                                                                          |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                        | 13b. CITY<br><b>Baltimore</b>                                                                                                            |                                                                         | 13c. STREET ADDRESS<br><b>7 Geranium Place</b>                                                                                                             |                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Coleman</b>                                                                                                                                                                                                                                                                                                                                                                                  |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                            |                                                                         |                                                                                                                                                            | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |                                                                                                 |                                                                                     |                                              |
| 16b. SOCIAL SECURITY NO.<br><b>219-18-1460</b>                                                                                                                                                                                                                                                                                                                                                                                            |                        | 17. INFORMANT<br><b>7 Geranium Place Balto., Md. 21220</b><br><b>John D. Pierce, husband</b>                                             |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Complication of multiple visceral &amp; skeletal injuries</b><br>8121<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |                        |                                                                                                                                          |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                       |                        |                                                                                                                                          |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                            |                        | 21b. TIME OF INJURY<br>HOUR MIN. MONTH DAY YEAR<br><b>11:40pm 5-19-79</b>                                                                |                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Passenger in taxi which was struck by another vehicle.</b>             |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                      |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>                                                               |                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Eastern Blvd. 1310 ft. Balto. Md.</b><br><b>W. Martin Blvd.</b>                                    |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .  |                        |                                                                                                                                          |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>                                                                                                                                                                                                                                                                                                                                                                                              |                        | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                      |                                                                         | MEDICAL EXAMINER                                                                                                                                           |                                                                                                               | DATE SIGNED <b>6-1-79</b>                                                                       |                                                                                     |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                         |                        | ADDRESS<br><b>111 Penn St.</b>                                                                                                           |                                                                         |                                                                                                                                                            |                                                                                                               |                                                                                                 |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                             |                        | 23b. DATE<br><b>6/5/79</b>                                                                                                               |                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>                                                                                           |                                                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |                                                                                     |                                              |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home PA 1407 Old Eastern Ave.</b>                                                                                                                                                                                                                                                                                                                                                           |                        |                                                                                                                                          |                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                                                         |                                                                                                               | 25b. REGISTRAR'S SIGNATURE<br><i>John D. Pierce</i>                                             |                                                                                     |                                              |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 7/76

100-14330

Dec 1, 1965

XX

John D. Jones

210-18-1402

2-1-1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14531

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARION PILLING</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 15 79</b>                                                                                                       |                                                                                      | 2b. HOUR<br><b>3:30 AM</b>                                                                      |                                                                |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>White</b>                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 31, 1895</b>                                                                                                  |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>                                                    |                                                                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KESWICK NURSING HOME</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietician</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>           |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                          | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                | 13c. CITY OR TOWN<br><b>Balto.</b>                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3333 N. Charles Street</b>           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John William Pilling Sr.</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Emma Boden</b>                                                                                     |                                                                                      |                                                                                                 |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>218-34-1258</b>                                                                                                              |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Carl Benson Towson, Md.</b>                                 |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b><br><b>496-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Idiopathic hypertrophic aortic stenosis</b>                                                                                                                                                                                          |                                                                                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                       |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                |
| 22a. I certify that (b) (this hospital) attended the deceased from <b>Sept 22 1976</b> to <b>June 15 1979</b> that (we) last saw the deceased alive on <b>June 15 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                             |                                                                                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                |
| 22b. SIGNATURE<br><b>W.B. Daniels Jr. M.D.</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                          | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED<br><b>6/15/79</b>                                                              |                                                                |
| 22d. PHYSICIAN'S NAME (credentials)<br><b>W.B. Daniels Jr. M.D.</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                          | 22e. ADDRESS<br><b>700 W. 40th St. Baltimore 21211</b>                                                                                                      |                                                                                      |                                                                                                 |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | 23b. DATE<br><b>6-16-79</b>                                                                                                                                 |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>                                   |                                                                |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Md.</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                          | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |                                                                                      |                                                                                                 |                                                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                             |                                                                                                                                          | 25a. REGISTRAR'S SIGNATURE<br><b>Ruby McBrady</b>                                                                                                           |                                                                                      |                                                                                                 |                                                                |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 3 2 1



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 1 4 5 3 2

|                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                       |                                                         | 2a. DATE OF DEATH                                                                                                                                        |                                      | 2b. HOUR                                                                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                             |                                                         | MONTH DAY YEAR                                                                                                                                           |                                      | 9:29 P.M.                                                                      |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                            |                                                         | 6 3 79                                                                                                                                                   |                                      |                                                                                |                                              |
| Virgil G. Pittman                                                                                                                                                                                                                                                            |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                       | 4. RACE                                                 | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)      | 7. UNDER 1 YEAR                                                                |                                              |
| M                                                                                                                                                                                                                                                                            | W                                                       | MONTH DAY YEAR                                                                                                                                           | 61                                   | MONTHS DAYS HOURS MIN.                                                         |                                              |
|                                                                                                                                                                                                                                                                              |                                                         | 7 1 17                                                                                                                                                   |                                      |                                                                                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                                |                                              |
| Washington, D.C.                                                                                                                                                                                                                                                             | U.S.A.                                                  |                                                                                                                                                          | Baltimore City MD                    |                                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                              |
| Baltimore                                                                                                                                                                                                                                                                    | St. Agnes Hospital                                      | Brick Layer                                                                                                                                              |                                      | Construction                                                                   |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                      |                                                         | 13a. INSIDE CITY LIMITS                                                                                                                                  | 13b. STREET ADDRESS                  |                                                                                |                                              |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN                                                                                                                                                                                                                                     |                                                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      | 1267 Birch Avenue                    |                                                                                |                                              |
| Md. Baltimore Baltimore                                                                                                                                                                                                                                                      |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                            |                                                         | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                      |                                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                            |                                                         | FIRST MIDDLE LAST                                                                                                                                        |                                      |                                                                                |                                              |
| Virgil G. Pittman                                                                                                                                                                                                                                                            |                                                         | Lillie Belle Jones                                                                                                                                       |                                      |                                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                            |                                                         | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                      | 17. INFORMANT ADDRESS                                                          |                                              |
| yes                                                                                                                                                                                                                                                                          |                                                         | 5-45 -- 9-46                                                                                                                                             |                                      | Julia Pittman 1267 Birch Ave. 21227                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):                                                                                                                                                   |                                                         |                                                                                                                                                          |                                      |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Cardiac Arrest                                                                                                                                                                                                                                                               |                                                         |                                                                                                                                                          |                                      |                                                                                | Sudden                                       |
| 410 - DUE TO, OR AS A CONSEQUENCE OF (b):                                                                                                                                                                                                                                    |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| Myocardial Infarction                                                                                                                                                                                                                                                        |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c):                                                                                                                                                                                                                                          |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| ASCD advanced                                                                                                                                                                                                                                                                |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                         |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                       |                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                      | 20a. AUTOPSY?                                                                  |                                              |
|                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                          |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                           |                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                              |
|                                                                                                                                                                                                                                                                              |                                                         | P.M. 19                                                                                                                                                  |                                      |                                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                       |                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                      | 21f. LOCATION CITY OR TOWN COUNTY STATE                                        |                                              |
|                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 74 to 6/3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so we did not see the body after death.) |                                                         |                                                                                                                                                          |                                      |                                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                               |                                                         | DEGREE                                                                                                                                                   |                                      | 22c. DATE SIGNED                                                               |                                              |
| Herbert J. Lewickas                                                                                                                                                                                                                                                          |                                                         | MD, ATTENDING PHYSICIAN                                                                                                                                  |                                      | 6/3/79                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                        |                                                         | 22e. ADDRESS                                                                                                                                             |                                      |                                                                                |                                              |
| Herbert J. Lewickas                                                                                                                                                                                                                                                          |                                                         | 5404 East Drive (21227)                                                                                                                                  |                                      |                                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                    |                                                         | 23b. DATE                                                                                                                                                |                                      | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                              |
| Burial                                                                                                                                                                                                                                                                       |                                                         | June 7, 1979                                                                                                                                             |                                      | New Cathedral                                                                  |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                    |                                                         | 24b. ADDRESS                                                                                                                                             |                                      | 25a. DATE REC'D. BY REGISTRAR                                                  |                                              |
| Amorose Funeral Home, Inc.                                                                                                                                                                                                                                                   |                                                         | 1328 Sulphur Sprg                                                                                                                                        |                                      | JUN 5 1979                                                                     |                                              |
|                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                          |                                      | 25b. REGISTRAR'S SIGNATURE                                                     |                                              |
|                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                          |                                      | [Signature]                                                                    |                                              |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                            |                                                                       |                                                                                                                                                            |                                                                               |                                                                                                       |                                                                                                                                            |                                                                                                                           |                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NINA PLATNIC                                                                                                                                                                                                                                                                          |  |                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>6 17 79                         |                                                                                                                                                            |                                                                               | 2b HOUR<br>11:55 AM                                                                                   |                                                                                                                                            |                                                                                                                           |                            |
| 3 SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br>CAUCASIAN                                                                                                        |                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>5 14 14                                                                                                               |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.                                                             |                                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                           |                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND                                                                                                                                                                                                                                                                                               |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                                                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                             |                                                                                                                                            |                                                                                                                           |                            |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                            |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |                                                                       |                                                                                                                                                            |                                                                               | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                          |                                                                                                                                            | 12b KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                                                               |                            |
| 13a STATE<br>Md                                                                                                                                                                                                                                                                                                                                  |  | 13b COUNTY<br>Baltimore                                                                                                    |                                                                       | 13c CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                               | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |                                                                                                                                            | 13e STREET ADDRESS<br>6604 Eberle Drive APT 203 21215                                                                     |                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN SILVERBERG ROSE                                                                                                                                                                                                                                                                                 |  |                                                                                                                            |                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                                                                                    |                                                                               | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |                                                                                                                                            |                                                                                                                           |                            |
| 16b SOCIAL SECURITY NO.<br>215-58-2134                                                                                                                                                                                                                                                                                                           |  |                                                                                                                            |                                                                       | 17 INFORMANT<br>MAURICE PLATNIC                                                                                                                            |                                                                               | ADDRESS<br>APT. 203 6604 EBERLE DR. #21215                                                            |                                                                                                                                            |                                                                                                                           |                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Colon rectal Carcinoma<br>1540<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                            |                                                                       |                                                                                                                                                            |                                                                               |                                                                                                       |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 years                                                                   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                              |  |                                                                                                                            |                                                                       |                                                                                                                                                            |                                                                               |                                                                                                       |                                                                                                                                            |                                                                                                                           |                            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                               | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |                                                                                                                                            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                          |  |                                                                                                                            | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                       |                                                                                                                                            |                                                                                                                           |                            |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                         |  |                                                                                                                            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                       |                                                                                                                                            |                                                                                                                           |                            |
| 22a I certify that (I) (this hospital) attended the deceased from 6/14/79 to 6/17/79, that (I) (we) lost<br>saw the deceased alive on 6/14/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                       |  |                                                                                                                            |                                                                       |                                                                                                                                                            |                                                                               |                                                                                                       |                                                                                                                                            |                                                                                                                           |                            |
| 22b SIGNATURE<br>Sheldon Goldgeier MD                                                                                                                                                                                                                                                                                                            |  |                                                                                                                            |                                                                       |                                                                                                                                                            | DEGREE<br>MD                                                                  |                                                                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                           | 22c DATE SIGNED<br>6-17-79 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>GOLDGEIER, SHELDON                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |                                                                       |                                                                                                                                                            | 22e ADDRESS<br>711 W 40 ST 21211                                              |                                                                                                       |                                                                                                                                            |                                                                                                                           |                            |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL                                                                                                                                                                                                                                                                                               |  |                                                                                                                            | 23b DATE<br>JUNE 18, 1979                                             |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br>MOSES MONTEPIORE                         |                                                                                                       | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                                                            |                                                                                                                           |                            |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                        |  |                                                                                                                            |                                                                       |                                                                                                                                                            | 25a DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                   |                                                                                                       | 25b REGISTRAR'S SIGNATURE<br>Anthony A. Brady                                                                                              |                                                                                                                           |                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14534

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                       |                                                                                                                                                          |                                                                                              |                                                                        |                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Charles Henry Polacek</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6-30-79</b>                                           |                                                                        | 2b. HOUR<br><b>2:45 PM</b>                         |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>White</b>                                                                                                                               | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 9, 1915</b>                                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                              |                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                            |                                                                        |                                                    |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of MD - MIEMASst. Foreman</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE C ORK FOR MOST OF WORKING LIFE)<br><b>Aviation</b>               |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Martin</b> |
| 13a. STATE<br><b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                | 13b. COUNTY<br><b>Anne Arundel</b>                                                                                                                    | 13c. CITY OR TOWN<br><b>Severn</b>                                                                                                                       | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>21144 1205 Delmont Rd. Severn, M.D.</b>      |                                                    |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry Polacek Jr.</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Amelia Hnyla</b>                                                                                        |                                                                                              |                                                                        |                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br><b>215-07-3253</b>                                                                                                           |                                                                                              | 17. INFORMANT (Brother)<br><b>William Polacek (Bro)</b>                |                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Perineum Pelvic abscess with synergistic gangrene</b><br><b>2506</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Acute Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Diabetes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                                       |                                                                                                                                                          |                                                                                              |                                                                        |                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cirrhosis</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                                       |                                                                                                                                                          |                                                                                              |                                                                        |                                                    |
| 19a. DATE OF OPERATION<br><b>6/25/79</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Synergistic gangrene Perineum</b>                                                                 |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br/>P.M. 19</b>                                                                                                                                                                                                                    |                                                                                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Shock Trauma</b>                                                    |                                                                                              |                                                                        |                                                    |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                         |                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/30</b> 19 <b>79</b> to <b>6/30</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/30</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                               |                                                                                                                                                       |                                                                                                                                                          |                                                                                              |                                                                        |                                                    |
| 22b. SIGNATURE<br><b>M. L. Lello</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                       | DEGREE<br><b>MD</b>                                                                                                                                      |                                                                                              | 22c. DATE SIGNED<br><b>6/30/79</b>                                     |                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. L. Lello</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                       | 22e. ADDRESS<br><b>Shock Trauma</b>                                                                                                                      |                                                                                              |                                                                        |                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                       | 23b. DATE<br><b>7/3/79</b>                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk. Glen Burnie A.A. Md.</b>        |                                                                        | 23d. LOCATION CITY OR TOWN COUNTY STATE            |
| 24. FUNERAL DIRECTOR NAME<br><b>B. H. Hopkins</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                       | ADDRESS<br><b>Singleton Funeral Home, Glen Burnie, Md.</b>                                                                                               |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1979</b>                     | 25b. REGISTRAR'S SIGNATURE<br><b>P. H. H. H.</b>   |

BP



Attended

W. L. J. 1/10

~~W. L. J. 1/10~~

W. L. J. 1/10

MD

Spine L. 1/10

W. L. J. 1/10



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14535

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |                                                    |                                                                                                                                                             |                                                                                      |                                                                           |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Max Polotnick                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6, 15, 1979 |                                                                                                                                                             |                                                                                      | 7b. HOUR<br>2:35 PM                                                       |                                                                                                                            |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>WHITE                                                                                                                     |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 1, 1911                                                                                                          |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |                                                    |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                    | 13b. COUNTY<br>BALTIMORE                                                                                                                                    |                                                                                      | 13c. CITY OR TOWN<br>BALTIMORE                                            |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS POLOTNICK                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ESTHER RESIDOR                                                                                             |                                                                                      |                                                                           |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>060-05-1808                                                               |                                                    | 17. INFORMANT<br>ADDRESS<br>HARVEY S. PERLE 11 HALCYON COURT (21208)                                                                                        |                                                                                      |                                                                           |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>4/69<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <u>GI bleed</u><br>(c) <u>Cor Pulmonale, Liver disease, Malnutrition</u>                  |  |                                                                                                                                      |                                                    |                                                                                                                                                             |                                                                                      |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                    |                                                                                                                                                             |                                                                                      |                                                                           |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                    |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                           |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                           |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> , 19 <u>79</u> , to <u>6/15</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                      |                                                    |                                                                                                                                                             |                                                                                      |                                                                           |                                                                                                                            |
| 22b. SIGNATURE<br>David Miskin MD                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |                                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br>6/15/79                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D Miskin M.D.                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                    | 22e. ADDRESS<br>Baltimore City Hosps.                                                                                                                       |                                                                                      |                                                                           |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>6/17/79                                                                                                                 |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH JACOB                                                                                                            |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FINKSBURG, MD.              |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                    | 6010 REISTERSTOWN RD.<br>BALTIMORE, MD. (212150)                                                                                                            |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                              |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |                                                    | 25b. REGISTRAR'S SIGNATURE<br>R. K. K...                                                                                                                    |                                                                                      |                                                                           |                                                                                                                            |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1400

1400

1400





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 3 6

REG. NO.

|                                                                                   |                                                                                                                                          |                                                                                                                                                            |                                                                                                |                                                               |                                  |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Patricia ANN Poole</b>                      |                                                                                                                                          |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>6 14 79</b>                                              |                                                               | 2b HOUR<br><b>1:20 AM</b>        |
| 3 SEX<br><b>Female</b>                                                            | 4 RACE<br><b>Black</b>                                                                                                                   | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>8 10 47</b>                                                                                                           |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b> YRS.              |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>A.A. Co., Md</b>                   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY MD.</b> |                                  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO. MD.</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Md. Hosp.</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed -</b>         |                                                               | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE<br><b>MARYLAND</b>                                                      | 13b COUNTY<br><b>A.A. Co</b>                                                                                                             | 13c CITY OR TOWN<br><b>Severna</b>                                                                                                                         | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>1853 Richfield Dr.</b>               |                                  |
| 14 FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Williams</b> LAST <b>Williams</b> |                                                                                                                                          | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>Holland</b> LAST <b>Holland</b>                                                                     |                                                                                                |                                                               |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>     |                                                                                                                                          | 16b SOCIAL SECURITY NO.                                                                                                                                    |                                                                                                | 17 INFORMANT<br><b>Richard Rooke</b>                          |                                  |
|                                                                                   |                                                                                                                                          |                                                                                                                                                            |                                                                                                | ADDRESS<br><b>1853 Richfield Dr.</b>                          |                                  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cardiac Respiratory Arrest**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**June 14/1977**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(b) **(1) Breast Ca**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                       |                                                                                                                                                                                                                                    |                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                           | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                      |                                                                                                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                    | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                   |                                                                                                                              |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/13</b> 19 <b>77</b> , to <b>6/14</b> 19 <b>77</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/14</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |                                                                       |                                                                                                                                                                                                                                    |                                                                                                                              |
| 22b SIGNATURE<br><b>Philip Konits</b>                                                                                                                                                                                                                                                                                                                            |                                                                       | DEGREE<br>ATTENDING <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | 22c DATE SIGNED<br><b>6/14/79</b>                                                                                            |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. Konits</b>                                                                                                                                                                                                                                                                                                         |                                                                       | 22e ADDRESS<br><b>B.C.R. 225, Grove St.</b>                                                                                                                                                                                        |                                                                                                                              |

|                                                                            |                            |                                                                |                                                                      |
|----------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------|----------------------------------------------------------------------|
| 23a BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT) <b>Burial</b>            | 23b DATE<br><b>6/18/79</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>John Wesley Church</b> | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Severna MARYLAND</b> |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Charles F. Hicks F.H. 1922 Forest Dr</b> |                            | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>             | 25b REGISTRAR'S SIGNATURE<br><b>Hickory</b>                          |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be filled in by the attending physician and completely filled in by the funeral director, but should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 4 2 3 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                  |                                                                                                                                                          | REG. NO. 7 9 1 4 5 3 7           |                                                                                                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        | 1. DECEASED NAME (TYPE OR PRINT) |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR |                                                                                                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        | Catherine M. (Billups) Pope      |                                                                                                                                                          | 8 0 6 0 8 7 9 10 25 P M          |                                                                                                                         |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                                                |                                  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |                                              |
| F                                                                                                                                                                                                                                                                                                                                                                    |  | B.                                                                                                     |                                  | 6 8 10                                                                                                                                                   |                                  | 69 YRS.                                                                                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |                                              |
| Va.                                                                                                                                                                                                                                                                                                                                                                  |  | USA                                                                                                    |                                  |                                                                                                                                                          |                                  | Balto. City MD.                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| Balto.                                                                                                                                                                                                                                                                                                                                                               |  | Provident Hosp                                                                                         |                                  |                                                                                                                                                          |                                  |                                                                                                                         |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                            |                                  | 13c. CITY OR TOWN                                                                                                                                        |                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| Md                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                  | Balto.                                                                                                                                                   |                                  | 13e. STREET ADDRESS                                                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                  |                                                                                                                                                          |                                  | 3624 Cottage Ave.                                                                                                       |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |                                  |                                                                                                                                                          |                                  |                                                                                                                         |                                              |
| Arthur Pope                                                                                                                                                                                                                                                                                                                                                          |  | Bertina Curry                                                                                          |                                  |                                                                                                                                                          |                                  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                                               |                                  | 17. INFORMANT                                                                                                                                            |                                  | ADDRESS                                                                                                                 |                                              |
| NO                                                                                                                                                                                                                                                                                                                                                                   |  | 219-20-7260                                                                                            |                                  | Carolyn Young                                                                                                                                            |                                  | 3624 Cottage Ave.                                                                                                       |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure.<br>586-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) RENAL SHUT DOWN.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                        |                                  |                                                                                                                                                          |                                  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                  |  |                                                                                                        |                                  |                                                                                                                                                          |                                  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                                                      |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                           |                                  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                  |                                                                                                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                  |                                                                                                                                                          |                                  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 05/30/1979 to 06/08/1979, that (I) (we) lost saw the deceased alive on 06/08/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                       |  |                                                                                                        |                                  |                                                                                                                                                          |                                  |                                                                                                                         |                                              |
| 22b. SIGNATURE J. Suregn                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                  | DEGREE                                                                                                                                                   |                                  | 22c. DATE SIGNED 6/8/79                                                                                                 |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.J. Suregn                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                  | 22e. ADDRESS Provident Hospital                                                                                                                          |                                  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                                              |                                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                               |  | 6/12/79                                                                                                |                                  | Cedar Hill Cem.                                                                                                                                          |                                  | Anne Arundel Co., Md.                                                                                                   |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                  | 25b. REGISTRAR'S SIGNATURE                                                                                              |                                              |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                  | JUN 11 1979                                                                                                                                              |                                  | J. Suregn                                                                                                               |                                              |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14538

|                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                |                                                                                                                                                            |                                                                                 |                                                                                               |                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM CLIFFORD PORTER</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 16, 1979</b>                     |                                                                                               | 2b. HOUR<br><b>2:08pm</b>                                                                       |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                             | 4 RACE<br><b>White</b>                                                                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 31, 1979</b>                                                                                                   |                                                                                 | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>0 0 15</b>                            |                                                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                              |                                                                                                 |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b> |                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                            | 13b. COUNTY<br><b>Carroll</b>                                                   | 13c. CITY OR TOWN<br><b>New Windsor</b>                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kenneth Clifford Porter</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Velma Marie Keller</b>       |                                                                                               |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                    |                                                                                 | 17 INFORMANT ADDRESS<br><b>Kenneth C. Porter, Same As #13.</b>                                |                                                                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>769-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory Failure and Subcutaneous Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory Distress Syndrome</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                                |                                                                                                                                                            |                                                                                 |                                                                                               |                                                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Prematurity</b>                                                                                                                                                                                                                                         |                                                                                                                                                |                                                                                                                                                            |                                                                                 |                                                                                               |                                                                                                 |
| 19a. DATE OF OPERATION<br><b>6/16</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Respiratory Distress Syndrome</b>                                                                   |                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                         |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                               |                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>None</b> |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Johns Hopkins Hospital</b>                                                    |                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                             |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/31, 1979</b> to <b>6/16, 1979</b> , that (I) (we) last saw the deceased alive on <b>6/16, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.                                                                     |                                                                                                                                                |                                                                                                                                                            |                                                                                 |                                                                                               |                                                                                                 |
| 22b. SIGNATURE<br><b>Shawn</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                                 | 22c. DATE SIGNED<br><b>6/16/79</b>                                                            |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Shawn</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                              |                                                                                 |                                                                                               |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 23b. DATE<br><b>6-19-1979</b>                                                                                                                              |                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Locust Grove</b>                                     |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Frederick, Md.</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                | COUNTY<br><b>Frederick</b>                                                                                                                                 |                                                                                 | STATE<br><b>Md.</b>                                                                           |                                                                                                 |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Charles W. Burrier, Jr., Sykesville, Md.</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                             |                                                                                               |                                                                                                 |
| ADDRESS<br><b>Sykesville, Md.</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                |                                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. ...</b>                              |                                                                                               |                                                                                                 |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                      |                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul Potler                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 28 79                                                                                                              |                                                                            | 2b. HOUR<br>6:20A                                                                    |                                                    |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>WHITE                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 1, 1902                                                                                                          |                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                           |                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                            |                                                    |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF OCCUPATION OR WORKING LIFE)<br>STEVEDORE |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>SENIOR DRIVER |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             | 13b. COUNTY                                                                                                                                                 | 13c. CITY<br>BALTIMORE                                                     |                                                                                      |                                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN POTLER                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HANNAH UNKNOWN                                                                                             |                                                                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO           |                                                    |
| 16b. SOCIAL SECURITY NO.<br>215-09-3279A                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>MRS. SOPHIE POTLER 1103 HAUBERT ST. 21230                                                                                       |                                                                            |                                                                                      |                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Chronic lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Stroke Dementia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 HRS<br>YEARS |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                      |                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                      |                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                    |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |                                                                            |                                                                                      |                                                    |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                            |                                                                                      |                                                    |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> 19 <u>79</u> to <u>6/28</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>6/27</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                  |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                      |                                                    |
| 22b. SIGNATURE<br><u>M. ZIMMERMAN</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                             | 22c. DEGREE<br>MD                                                                                                                                           |                                                                            | 22d. DATE SIGNED<br>6/28/79                                                          |                                                    |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. ZIMMERMAN                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                             | 22f. ADDRESS<br>Mercy Hospital                                                                                                                              |                                                                            |                                                                                      |                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                             | 23b. DATE<br>6/29/79                                                                                                                                        |                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN                               |                                                    |
| 23d. LOCATION<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 23e. COUNTY<br>MARYLAND                                                                                                                                     |                                                                            |                                                                                      |                                                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 24b. ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                      |                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979                                          |                                                    |
| 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                      |                                                    |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14540

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                       |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Nellie K. POWERS                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                       |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br>JUNE 3, 1979                              |                                                                                                | 2b HOUR<br>10 P M                                                                                                         |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                      | 4 RACE<br>White                                                                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 23, 1886                                                                                                         |                                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                 | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                              | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1700 Meridene Drive #204 |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                   |                                                                                                                           |
| 13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                       | 13b COUNTY                                                                                                                                                 | 13c CITY OR TOWN<br>Baltimore                                                | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>1700 Meridene Drive #204                                                                            |
| 14 FATHER'S NAME<br>FIRST William MIDDLE H. LAST Wilson                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST Annie MIDDLE M. LAST Kemp                                                                                                 |                                                                              |                                                                                                |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                       | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>218-54-3319                                                                                       | 17 INFORMANT ADDRESS<br>Mrs. Elizabeth Countess Balto., Md.                  |                                                                                                |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 Days<br>10+ yrs |                                                                                                                                       |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                   |                                                                                                                                       |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                       | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                              | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |                                                                                                                                       | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                              | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |                                                                                                                                       | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                              | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from <u>7/8</u> 19 <u>77</u> to <u>3 June 79</u> , that (I) <del>was</del> last saw the deceased alive on <u>22 May 79</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <del>did</del> (did not) view the body after death.                                                        |                                                                                                                                       |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                           |
| 22b SIGNATURE<br><u>Charles F. O'Donnell</u>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |                                                                              | 22c DATE SIGNED<br><u>6/4/79</u>                                                               |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. C. F. O'Donnell, M.D.                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                       | 22e ADDRESS<br>7501 York Road Balto., Md.                                                                                                                  |                                                                              |                                                                                                |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   | 23b DATE<br>6-7-79                                                                                                                    | 23c NAME OF CEMETERY OR CREMATORY<br>New Cathedral                                                                                                         |                                                                              | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                       | 25a DATE REC'D. BY REGISTRAR<br>JUN 5 1979                                                                                                                 |                                                                              | 25b REGISTRAR'S SIGNATURE<br><u>L. J. H. H. H.</u>                                             |                                                                                                                           |

U F C P 1 3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                |  | FIRST                                                                                                                              |  | MIDDLE                                                                                                                             |  | LAST                                                                                                                               |  | 2a. DATE OF DEATH                                                                                                                                  |  | MONTH                                                                                                                              |  | DAY                                                                                                                                |  | YEAR                                                                                                                               |  | 2b. HOUR                                                                                                                           |  |
| Robert                                                                                                                             |  | P                                                                                                                                  |  | r                                                                                                                                  |  | e                                                                                                                                  |  | 6/2/79                                                                                                                                             |  | 7                                                                                                                                  |  | 1                                                                                                                                  |  | 4                                                                                                                                  |  | 3:45 P.M.                                                                                                                          |  |
| 3. SEX                                                                                                                             |  | 4. RACE                                                                                                                            |  | 5. DATE OF BIRTH                                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                    |  | 7. IF UNDER 1 YEAR                                                                                                                                 |  | 8. IF UNDER 1 YEAR                                                                                                                 |  | 9. IF UNDER 1 YEAR                                                                                                                 |  | 10. IF UNDER 1 YEAR                                                                                                                |  | 11. IF UNDER 1 YEAR                                                                                                                |  |
| male                                                                                                                               |  | Black                                                                                                                              |  | 11 27 07                                                                                                                           |  | 71 YRS                                                                                                                             |  | MONTHS                                                                                                                                             |  | DAYS                                                                                                                               |  | HOURS                                                                                                                              |  | MIN.                                                                                                                               |  |                                                                                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                               |  | 10. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                              |  | 11. BALTIMORE CITY OR COUNTY OF DEATH                                                                                              |  | 12. BALTIMORE CITY OR COUNTY OF DEATH                                                                                              |  | 13. BALTIMORE CITY OR COUNTY OF DEATH                                                                                              |  | 14. BALTIMORE CITY OR COUNTY OF DEATH                                                                                              |  |
| Baltimore Md                                                                                                                       |  | US                                                                                                                                 |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                      |  | Baltimore City MD                                                                                                                  |  |                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |
| 10. CITY OR TOWN OF DEATH                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                  |  | 13a. INSIDE CITY LIMITS?                                                                                                                           |  | 13b. STREET ADDRESS                                                                                                                |  | 13c. STREET ADDRESS                                                                                                                |  | 13d. STREET ADDRESS                                                                                                                |  | 13e. STREET ADDRESS                                                                                                                |  |
| Baltimore Md                                                                                                                       |  | Provident Hosp.                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                |  | 1711 - DuKeland Street                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |
| 13a. STATE                                                                                                                         |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN                                                                                                                  |  | 13d. INSIDE CITY LIMITS?                                                                                                           |  | 13e. STREET ADDRESS                                                                                                                                |  | 13f. STREET ADDRESS                                                                                                                |  | 13g. STREET ADDRESS                                                                                                                |  | 13h. STREET ADDRESS                                                                                                                |  | 13i. STREET ADDRESS                                                                                                                |  |
| Md                                                                                                                                 |  |                                                                                                                                    |  | Balt                                                                                                                               |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 1711 - DuKeland Street                                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |
| 14. FATHER'S NAME                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                                                                                           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                  |  | 16b. SOCIAL SECURITY NO.                                                                                                           |  | 17. INFORMANT                                                                                                                                      |  | 18. ADDRESS                                                                                                                        |  | 19. ADDRESS                                                                                                                        |  | 20. ADDRESS                                                                                                                        |  | 21. ADDRESS                                                                                                                        |  |
| Anderson                                                                                                                           |  | Henrietta                                                                                                                          |  | No                                                                                                                                 |  | 606-04-0101                                                                                                                        |  | Robert Prescott                                                                                                                                    |  | SON                                                                                                                                |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                           |  | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  | 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                           |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  | PART 1. DEATH WAS CAUSED BY:                                                                                                       |  |
| IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  | IMMEDIATE CAUSE (a)                                                                                                                |  |
| 436 -                                                                                                                              |  | 436 -                                                                                                                              |  | 436 -                                                                                                                              |  | 436 -                                                                                                                              |  | 436 -                                                                                                                                              |  | 436 -                                                                                                                              |  | 436 -                                                                                                                              |  | 436 -                                                                                                                              |  | 436 -                                                                                                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  |
| (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  | (b) Cardiac Arrest                                                                                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                     |  |
| (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  | (c) Acute CVA & malignant Hypertension                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |
| Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  | Respiratory insufficiency Probable myocardial infarction                                                                           |  |
| 19a. DATE OF OPERATION                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY?                                                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                     |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY                                                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                     |  | 22a. DATE SIGNED                                                                                                                   |  | 22b. DATE SIGNED                                                                                                                   |  |
|                                                                                                                                    |  |                                                                                                                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                           |  |                                                                                                                                                    |  | HOUR A.M. MONTH DAY YEAR                                                                                                           |  |                                                                                                                                    |  | 6/3/79                                                                                                                             |  | 6/3/79                                                                                                                             |  |
| 21d. INJURY OCCURRED                                                                                                               |  | 21e. PLACE OF INJURY                                                                                                               |  | 21f. LOCATION                                                                                                                      |  | 21g. LOCATION                                                                                                                      |  | 21h. LOCATION                                                                                                                                      |  | 21i. LOCATION                                                                                                                      |  | 21j. LOCATION                                                                                                                      |  | 21k. LOCATION                                                                                                                      |  | 21l. LOCATION                                                                                                                      |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |  | STREET                                                                                                                             |  | CITY OR TOWN                                                                                                                       |  | COUNTY                                                                                                                                             |  | STATE                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22b. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22c. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22d. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22e. I certify that (I) (this hospital) attended the deceased from                                                                                 |  | 22f. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22g. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22h. I certify that (I) (this hospital) attended the deceased from                                                                 |  | 22i. I certify that (I) (this hospital) attended the deceased from                                                                 |  |
| above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  | above, (I) (we) (did) (did not) view the body after death.                                                                         |  |
| 22b. SIGNATURE                                                                                                                     |  | 22c. SIGNATURE                                                                                                                     |  | 22d. SIGNATURE                                                                                                                     |  | 22e. SIGNATURE                                                                                                                     |  | 22f. SIGNATURE                                                                                                                                     |  | 22g. SIGNATURE                                                                                                                     |  | 22h. SIGNATURE                                                                                                                     |  | 22i. SIGNATURE                                                                                                                     |  | 22j. SIGNATURE                                                                                                                     |  |
| Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                                               |  | Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                               |  | Silverneke Roundtree                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                              |  | 22e. ADDRESS                                                                                                                       |  | 22f. ADDRESS                                                                                                                       |  | 22g. ADDRESS                                                                                                                       |  | 22h. ADDRESS                                                                                                                                       |  | 22i. ADDRESS                                                                                                                       |  | 22j. ADDRESS                                                                                                                       |  | 22k. ADDRESS                                                                                                                       |  | 22l. ADDRESS                                                                                                                       |  |
| Silverneke Roundtree                                                                                                               |  | Provident Hosp. Liberty Heights                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                    |  | Provident Hosp. Liberty Heights                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                          |  | 23b. DATE                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                 |  | 23d. LOCATION                                                                                                                      |  | 23e. LOCATION                                                                                                                                      |  | 23f. LOCATION                                                                                                                      |  | 23g. LOCATION                                                                                                                      |  | 23h. LOCATION                                                                                                                      |  | 23i. LOCATION                                                                                                                      |  |
| Burial                                                                                                                             |  | 6/7/79                                                                                                                             |  | Cedar Hill Cem.                                                                                                                    |  | Anne Arundel Co., Md.                                                                                                              |  | Anne Arundel Co., Md.                                                                                                                              |  | Anne Arundel Co., Md.                                                                                                              |  | Anne Arundel Co., Md.                                                                                                              |  | Anne Arundel Co., Md.                                                                                                              |  | Anne Arundel Co., Md.                                                                                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  | 24. FUNERAL DIRECTOR                                                                                                               |  |
| Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  | Wm C. March F/H                                                                                                                    |  |
| ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                                            |  | ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                            |  | ADDRESS                                                                                                                            |  |
| 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  | 1101 E. North Ave.                                                                                                                 |  |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE                                                                                                         |  | 25c. REGISTRAR'S SIGNATURE                                                                                                         |  | 25d. REGISTRAR'S SIGNATURE                                                                                                         |  | 25e. REGISTRAR'S SIGNATURE                                                                                                                         |  | 25f. REGISTRAR'S SIGNATURE                                                                                                         |  | 25g. REGISTRAR'S SIGNATURE                                                                                                         |  | 25h. REGISTRAR'S SIGNATURE                                                                                                         |  | 25i. REGISTRAR'S SIGNATURE                                                                                                         |  |
| JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                                         |  | JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                         |  | JUN 7 1979                                                                                                                         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 4 2

REG. NO.

|                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                  |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                           |                                                                     | 2b. HOUR                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                        |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                           |                                                                     | 2b. HOUR                                                                       |  |
| Beulah                                                                                                                                                                                                                                                  |                                                                                                        | June 21 1979                                                                                                                                                |                                                                     | 6:30 A.                                                                        |  |
| 3. SEX                                                                                                                                                                                                                                                  | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. BALTIMORE CITY OR COUNTY OF DEATH                                           |  |
| Female                                                                                                                                                                                                                                                  | Negro                                                                                                  | February 2, 1904                                                                                                                                            | 75 YRS                                                              | Baltimore City MD.                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                                |  |
| Maryland                                                                                                                                                                                                                                                | U.S.A.                                                                                                 |                                                                                                                                                             | Housewife                                                           |                                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                                                |  |
| Baltimore                                                                                                                                                                                                                                               | 901 W. Saratoga Street                                                                                 |                                                                                                                                                             |                                                                     |                                                                                |  |
| 13a. STATE                                                                                                                                                                                                                                              | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |  |
| Maryland                                                                                                                                                                                                                                                | --                                                                                                     | Baltimore                                                                                                                                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 901 W. Saratoga Street                                                         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                             | 17. INFORMANT ADDRESS                                               |                                                                                |  |
| William                                                                                                                                                                                                                                                 | Millie                                                                                                 |                                                                                                                                                             | Lewis Spriggs/Rd. 4 Princeton, N.J.                                 |                                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                       | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT ADDRESS                                                                                                                                       |                                                                     |                                                                                |  |
| no                                                                                                                                                                                                                                                      | 217-07-3256 A                                                                                          |                                                                                                                                                             |                                                                     |                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4392 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>LEUC</i> <i>geno</i>                            |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                     |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                     | 20a. AUTOPSY?                                                                  |  |
|                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                      |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                                |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|                                                                                                                                                                                                                                                         |                                                                                                        | P.M. 19                                                                                                                                                     |                                                                     |                                                                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                  |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                     | 21f. LOCATION CITY OR TOWN COUNTY STATE                                        |  |
|                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 21</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (it) did not visit the body after death. |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                          |                                                                                                        | DEGREE                                                                                                                                                      |                                                                     | 22c. DATE SIGNED                                                               |  |
| <i>H. Nakazona</i>                                                                                                                                                                                                                                      |                                                                                                        | MD                                                                                                                                                          |                                                                     | 6-23-79                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                   |                                                                                                        | 22e. ADDRESS                                                                                                                                                |                                                                     |                                                                                |  |
| H. NAKAZONA                                                                                                                                                                                                                                             |                                                                                                        | 519 W. Lincolnton St. Balto 21201                                                                                                                           |                                                                     |                                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                               | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                     | 23d. LOCATION CITY OR TOWN COUNTY STATE                                        |  |
| Burial                                                                                                                                                                                                                                                  | June 26, 1979                                                                                          | Berkly Memorial                                                                                                                                             |                                                                     | Darlington (Harford Co.) Md.                                                   |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                               |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |  |
| Marshall W. Jones, Jr. / 4101 Edmondson Ave.                                                                                                                                                                                                            |                                                                                                        | JUN 27 1979                                                                                                                                                 |                                                                     | <i>R. J. H. H. H.</i>                                                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 4 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sennie Julia Prinity                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 16 1979                                                                                                         |  | 2b. HOUR<br>M                                                                                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 9 09                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CTY MD.                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | 13b. COUNTY<br>Balto.                                                                                                                                       |  | 13c. CITY OR TOWN<br>Balto.                                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Perzel                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Koslab                                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>170 05 1421                                                          |  | 17. INFORMANT<br>ADDRESS<br>Joan Secora 5201 Disney Ave. Balto. Md.                                                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma Colon 2 mos.<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                         |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>Sept. 1978                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma Rectum                                                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1978, to June 16, 1979, that (I) (we) lost saw the deceased alive on June 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                   |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>B. Martin Middleton MD                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  | DEGREE<br>MD                                                                                                                                                |  | 22c. DATE SIGNED<br>6/16/79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. Martin Middleton MD                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | 22e. ADDRESS<br>3350 Wilkens Ave Balto Md 21229                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>6/19/79                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Laureldale Cemetery Reading                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pennsylvania                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce 4001 Ritchie Hgwy                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McBrady                                                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------|--|----------------------------------------------|-----|------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                 |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2a. DATE OF DEATH   |  | MONTH                                        | DAY | YEAR             | 2b. HOUR |
| Carl                                                                                                                                                                |  | Anthony                                                                                                |  | Punte                                                                                                                                                    |  |                                                                     |  | 6                   |  | 12                                           | 79  | 5P               |          |
| 3. SEX                                                                                                                                                              |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 74 HRS                              |     |                  |          |
| Male                                                                                                                                                                |  | White                                                                                                  |  | 8 15 1906                                                                                                                                                |  | 72                                                                  |  | MONTHS              |  | DAYS                                         |     | HOURS MIN.       |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                                              |     |                  |          |
| Maryland                                                                                                                                                            |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City                                                      |  |                     |  |                                              |     | MD.              |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                                              |     |                  |          |
| Baltimore                                                                                                                                                           |  | 4531 Furley Avenue                                                                                     |  | Heat Treater                                                                                                                                             |  | Balto. Tool Wks                                                     |  |                     |  |                                              |     |                  |          |
| 13a. STATE                                                                                                                                                          |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS |  |                                              |     |                  |          |
| Maryland                                                                                                                                                            |  |                                                                                                        |  | Baltimore                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4531 Furley Avenue  |  |                                              |     |                  |          |
| 14. FATHER'S NAME                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| John                                                                                                                                                                |  | Bernard                                                                                                |  | Mary                                                                                                                                                     |  | Elizabeth                                                           |  | Krogmann            |  |                                              |     |                  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                   |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                     |  |                                              |     |                  |          |
| No                                                                                                                                                                  |  | 212-05-4459                                                                                            |  | Carl W. Punte                                                                                                                                            |  | 3412 Lansdowne Ct.                                                  |  |                     |  |                                              |     |                  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |                  |          |
| IMMEDIATE CAUSE (a) <u>Carcinoma, prostate</u>                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  | + 6 mos                                      |     |                  |          |
| 185- DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| None                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| 19a. DATE OF OPERATION                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                                              |     |                  |          |
| None                                                                                                                                                                |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                                              |     |                  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                  |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                     |  |                                              |     |                  |          |
|                                                                                                                                                                     |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
|                                                                                                                                                                     |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| 21d. INJURY OCCURRED                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                            |  | CITY OR TOWN                                                        |  | COUNTY              |  | STATE                                        |     |                  |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                 |  |                                                                                                        |  | STREET                                                                                                                                                   |  |                                                                     |  |                     |  |                                              |     |                  |          |
| 22a. I certify that (if this hospital attended the deceased from <u>4/79</u> , 19 <u>79</u> , to <u>6/12/79</u> , 19 <u>79</u> , that (1) <u>we</u> lost            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| saw the deceased give an <u>ob</u> <u>6/12/79</u> 19 <u>79</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| 22b. SIGNATURE                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  | DEGREE                                       |     | 22c. DATE SIGNED |          |
| <u>Bernard J. Fikna</u> MD                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     | 6.13.79          |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  | 22e. ADDRESS                                 |     |                  |          |
| BERNARD J. FIKNA, M.D., A.B.F.P.                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                     |  | 404 BOWLEYS QUARTERS ROAD/21220              |     |                  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                           |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  | CITY OR TOWN        |  | COUNTY                                       |     | STATE            |          |
| Burial                                                                                                                                                              |  | 6/15/79                                                                                                |  | Sacred Heart of Jesus                                                                                                                                    |  | Dundalk                                                             |  | Baltimore           |  | Md.                                          |     |                  |          |
| 24. FUNERAL DIRECTOR                                                                                                                                                |  | 25a. DATE                                                                                              |  | 25b. REGISTRATION NO.                                                                                                                                    |  |                                                                     |  |                     |  |                                              |     |                  |          |
| NAME                                                                                                                                                                |  | ADDRESS                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |
| Lassahn Funeral Home                                                                                                                                                |  | 7401 Belair Road                                                                                       |  |                                                                                                                                                          |  |                                                                     |  |                     |  |                                              |     |                  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#16, Film G533 7/11/79 kam

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 5 4 5

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                        |       |                                                                     |                                                                                |                                   |                                                                |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE                                                                 | LAST  | 2a. DATE OF DEATH                                                   | MONTH                                                                          | DAY                               | YEAR                                                           | 2b. HOUR |
| Kinnon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                        | Purdy | June 28, 1979                                                       |                                                                                |                                   |                                                                | 1:45 AM  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |                                                                        |       | 6. AGE                                                              | 7. IF UNDER 1 YEAR                                                             |                                   | 8. IF UNDER 1 YEAR                                             |          |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Black                                                                                                     | MONTH DAY YEAR<br>03 29 1920                                                                                                                                |                                                                        |       | 59                                                                  | MONTHS DAYS                                                                    |                                   | HOURS MIN.                                                     |          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        |       | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                |                                   |                                                                |          |
| North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | U.S.A.                                                                                                    |                                                                                                                                                             |                                                                        |       | Baltimore City MD.                                                  |                                                                                |                                   |                                                                |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |                                                                        |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                |          |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Provident Hospital                                                                                        |                                                                                                                                                             |                                                                        |       | Laborer                                                             |                                                                                | Beth. Steel                       |                                                                |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                        |       | 13b. COUNTY                                                         |                                                                                |                                   |                                                                |          |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                        |       |                                                                     |                                                                                |                                   |                                                                |          |
| 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                        |       | 13d. INSIDE CITY LIMITS?                                            |                                                                                |                                   |                                                                |          |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                        |       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                |                                   |                                                                |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                        |       | 15. MOTHER'S MAIDEN NAME                                            |                                                                                |                                   |                                                                |          |
| Eddie Purdy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                        |       | Seabery                                                             |                                                                                |                                   |                                                                |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                        |       | 16b. SOCIAL SECURITY NO.                                            |                                                                                |                                   |                                                                |          |
| Yes WWII                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                        |       | 240-18-1534-4                                                       |                                                                                |                                   |                                                                |          |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                        |       | ADDRESS                                                             |                                                                                |                                   |                                                                |          |
| Mrs. Mary E. Purdy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                        |       | 1905 Division St.                                                   |                                                                                |                                   |                                                                |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Recurrent Cardiac arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ventricular Tachycardia, Arteriosclerosis, Heart Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Disease</u> |                                                                                                           |                                                                                                                                                             |                                                                        |       |                                                                     |                                                                                |                                   |                                                                |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |       |                                                                     | 20a. AUTOPSY?                                                                  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                        |       |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |       |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |                                                                |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |       |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |                                                                |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> 19 <u>79</u> to <u>6/28</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                                                                                                                                               |                                                                                                           |                                                                                                                                                             | 22b. SIGNATURE<br><u>Philip G. Cobb M.D.</u>                           |       |                                                                     | 22c. DATE SIGNED<br><u>6/28/79</u>                                             |                                   | 22d. ADDRESS                                                   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             | 23b. DATE                                                              |       |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |          |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | July 2, 79                                                             |       |                                                                     | Arbutus Mem. Park                                                              |                                   | Baltimore County Md.                                           |          |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                        |       | 25a. DATE REC'D. BY REGISTRAR                                       |                                                                                |                                   |                                                                |          |
| Herbert E. Nutter 3035 W. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                        |       | JUL 6 1979                                                          |                                                                                |                                   |                                                                |          |
| 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. Brady</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                        |       |                                                                     |                                                                                |                                   |                                                                |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |  |        |  |                                                         |  |                                    |  |                                                                                                                                      |  | 79                                                             |  | 14546                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------|--|---------------------------------------------------------|--|------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                            |  |        |  | REG. NO.                                                |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |  |        |  | 2a DATE OF DEATH                                        |  |                                    |  | MONTH                                                                                                                                |  | DAY                                                            |  | YEAR                             |  |
| FIRST MIDDLE LAST<br><b>Annie Queen</b>                                                                                                                                                                                                                                                                                                                           |  |        |  | 6                                                       |  | 3                                  |  | 79                                                                                                                                   |  | 2:25                                                           |  | P.M.                             |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE |  | 5. DATE OF BIRTH                                        |  |                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                       |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS.                 |  |
| F                                                                                                                                                                                                                                                                                                                                                                 |  | B      |  | 5-15-01                                                 |  |                                    |  | 78                                                                                                                                   |  | YRS.                                                           |  |                                  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          |  |        |  | 7b CITIZEN OF WHAT COUNTRY?                             |  |                                    |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                  |  |                                                                |  |                                  |  |
| Md.                                                                                                                                                                                                                                                                                                                                                               |  |        |  | USA                                                     |  |                                    |  | Baltimore City                                                                                                                       |  |                                                                |  | MD.                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                          |  |        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |                                    |  | 12a USUAL OCCUPATION                                                                                                                 |  |                                                                |  | 12b KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                    |  |        |  | Sinai Hospital                                          |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                         |  |        |  | 13b COUNTY                                              |  |                                    |  | 13c CITY OR TOWN                                                                                                                     |  |                                                                |  | 13d INSIDE CITY LIMITS?          |  |
| House in Pine                                                                                                                                                                                                                                                                                                                                                     |  |        |  | Baltimore Md.                                           |  |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                  |  |                                                                |  | 3751 Dolfield Ave.               |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                  |  |        |  | 15. MOTHER'S MAIDEN NAME                                |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| FIRST MIDDLE LAST<br>Moore                                                                                                                                                                                                                                                                                                                                        |  |        |  | FIRST MIDDLE LAST                                       |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                       |  |        |  | 16b SOCIAL SECURITY NO.                                 |  |                                    |  | 17 INFORMANT                                                                                                                         |  |                                                                |  | ADDRESS                          |  |
| NO                                                                                                                                                                                                                                                                                                                                                                |  |        |  | 218-72-6214                                             |  |                                    |  | Pearl Queen                                                                                                                          |  |                                                                |  | 3751 Dolfield Ave.               |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u><br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |        |  |                                                         |  |                                    |  |                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                |  |        |  |                                                         |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  |        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  |                                    |  | 20a AUTOPSY?                                                                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  |        |  |                                                         |  |                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |  |        |  | 21b. TIME OF INJURY                                     |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                       |  |                                                                |  |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  |        |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                               |  |        |  | 21e PLACE OF INJURY                                     |  |                                    |  | 21f. LOCATION                                                                                                                        |  | CITY OR TOWN COUNTY STATE                                      |  |                                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |        |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  |                                    |  | STREET                                                                                                                               |  |                                                                |  |                                  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/2</u> 19 <u>79</u> , to <u>6/3</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |        |  |                                                         |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                    |  |        |  | DEGREE                                                  |  |                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                               |  |                                  |  |
| <u>Chris Myun Han</u>                                                                                                                                                                                                                                                                                                                                             |  |        |  | MD                                                      |  |                                    |  | house                                                                                                                                |  | 6/3/79                                                         |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                             |  |        |  | 22e ADDRESS                                             |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| CHRIS MYUN HAN MD                                                                                                                                                                                                                                                                                                                                                 |  |        |  | SINAI HOSPITAL                                          |  |                                    |  |                                                                                                                                      |  |                                                                |  |                                  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                          |  |        |  | 23b. DATE                                               |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                                                                                                                      |  | 23d. LOCATION                                                  |  |                                  |  |
| Burial                                                                                                                                                                                                                                                                                                                                                            |  |        |  | 6/6/79                                                  |  | King Memorial Pk.                  |  |                                                                                                                                      |  | Baltimore Co., Md.                                             |  |                                  |  |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                               |  |        |  | 25a. DATE REC'D. BY REGISTRAR                           |  |                                    |  | 25b. REGISTRAR'S SIGNATURE                                                                                                           |  |                                                                |  |                                  |  |
| NAME ADDRESS<br>Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                 |  |        |  | JUN 7 1979                                              |  |                                    |  | <u>Christy K. Brady</u>                                                                                                              |  |                                                                |  |                                  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



10

1-2-2-1

124

1000

310-12-814 Plant Number 3021 Holifield Ave.

no

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14547

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |                                                                                                                                          |                                                                             |                                                                                                                                                             |                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CONRAD B. QUEEN</b>                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                          | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>6 22 19 79</b> |                                                                                                                                                             | 2b. HOUR<br>12:46 PM                                                                |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>black</b>     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 15 51</b>                                                                                     | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>28 YRS.</b>                        | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>                                                                                                                 | IF UNDER 24 HRS.<br>HOURS MIN<br><b>0 0</b>                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                             |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     |
| 9. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                             |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>                                                                          |                                                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                            |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                     |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                             | 13b. COUNTY<br><b>Baltimore</b>                                                                                                          |                                                                             | 13c. STREET ADDRESS<br><b>2572 Fairmount Ave</b>                                                                                                            |                                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Queen</b>                                                                                                                                                                                                                                                                                                                                                                             |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Elizabeth Queen</b>                                                             |                                                                             |                                                                                                                                                             |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                            |                             | 16b. SOCIAL SECURITY NO.                                                                                                                 |                                                                             | 17. INFORMANT<br>ADDRESS<br><b>MARY Queen 815 Lennox Avenue</b>                                                                                             |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4512</b><br>IMMEDIATE CAUSE (a) <b>Pulmonary embolism secondary to leg vein</b><br><b>XXXXXXXXXXXXXXXXXXXX</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                         |                             |                                                                                                                                          |                                                                             |                                                                                                                                                             |                                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                             |                                                                                                                                          |                                                                             |                                                                                                                                                             |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |                                                                             |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                             |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                              |                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |                                                                                                                                          |                                                                             |                                                                                                                                                             |                                                                                     |
| ACTUAL SIGNATURE<br><b>H.R. Guard</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                             | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                      |                                                                             | DATE SIGNED<br><b>6/23/79</b>                                                                                                                               |                                                                                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |                             | ADDRESS<br><b>111 Penn Street</b>                                                                                                        |                                                                             |                                                                                                                                                             |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                            | 23b. DATE<br><b>6-26-79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                            |                                                                             | 23d. LOCATION<br>CITY OR TOWN<br><b>Balt</b>                                                                                                                | COUNTY<br><b>MD.</b>                                                                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. Brown</b>                                                                                                                                                                                                                                                                                                                                                                                  |                             | ADDRESS<br><b>1206 28th W. Wood Ave.</b>                                                                                                 |                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                         |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |                                                                                                                                          |                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>                                                                                                        |                                                                                     |

TABLE 1

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 5 8532 6/27/79 83

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO.

14548

|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                               |                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Stella J. Raber</i>                                                                                                                                                                                                                                                                                                            |                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 16 79</i>                                                                                                       |                                                                                                | 2b HOUR<br><i>9:45 P.M.</i>                                                   |                                  |
| 3 SEX<br><i>female</i>                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br><i>white</i>                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>June 16, 1901</i>                                                                                                  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i>                                                    | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><i>YRS</i>                      |                                  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Mt. Carmel, Pa.</i>                                                                                                                                                                                                                                                                                                                            | 9b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                  | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD                                |                                                                               |                                  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                 | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospital</i> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>housewife</i>            |                                                                               | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>PA.</i>                                                                                                                                                                                                                                                                       |                                                                                                                                            | 13b CITY OR TOWN<br><i>Mt. Carmel Township</i>                                                                                                             | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d STREET ADDRESS<br><i>336 S. Beech St.</i>                                 |                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Stanley Glowacki</i>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown unknown</i>                                                                                     |                                                                                                | 16 ADDRESS<br><i>Pa. 231 S. Oak St., Mt. Carmel</i>                           |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 16b SOCIAL SECURITY NO.<br><i>180-07-8376</i>                                                                                                              |                                                                                                | 17 INFORMANT<br><i>Charles H. Raber</i>                                       |                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>1749 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>Metastatic Breast Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                               |                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>_____                                                                                                                                                                                                                                                     |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                               |                                  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      |                                                                                                                                            | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |                                  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |                                                                                                                                            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>2/26</i> 19 <i>79</i> to <i>6/16</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/16</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                    |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                               |                                  |
| 22b SIGNATURE<br><i>Simon Bardin</i>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | DEGREE                                                                                                                                                     |                                                                                                | 22c DATE SIGNED<br><i>6/16/79</i>                                             |                                  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Simon Bardin</i>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            | 22e ADDRESS<br><i>Balto City Hospital</i>                                                                                                                  |                                                                                                |                                                                               |                                  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>burial</i>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            | 23b DATE<br><i>6-20-79</i>                                                                                                                                 |                                                                                                | 23c NAME OF CEMETERY OR CREMATORY<br><i>Mt. Carmel Cem'ty</i>                 |                                  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Mt. Carmel Township, Pa.</i>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Leonard J. Ruck, Inc. Balto., Md.</i>                                                                            |                                                                                                |                                                                               |                                  |
| 25a DATE REC'D. BY REGISTRAR<br><i>JUN 18 1979</i>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            | 25b REGISTRAR'S SIGNATURE<br><i>Anthony Raber</i>                                                                                                          |                                                                                                |                                                                               |                                  |

BP

6441


$$\int_{\mathbb{R}^n} \int_{\mathbb{R}^n} \frac{1}{|x-y|^{n-2}} dx dy = \infty.$$

4568 • J. Neurosci., July 26, 2006 • 26(30):4562–4568

Figure 1

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST (SZANDLA) MIDDLE LAST (RACHMAN)

① Szandla

20. DATE OF DEATH

6

14

79

3:10 A

M

3. SEX

FEMALE

4. RACE

W HITE

5. DATE OF BIRTH

July

10

1900

6. AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Poland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

CITY

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Levinthal Hebrew Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

AT HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

6513 Wickfield Rd.

14. FATHER'S NAME

JOSEPH

MIDDLE

LAST

CHAIT

15. MOTHER'S MAIDEN NAME

HINDA

MIDDLE

LAST

UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

215-56-6781

17. INFORMANT

MRS. TOBA BURSTYN

6513 WICKFIELD RD. BALTO., MD 21209

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

7070

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c) CHF

DUE TO, OR AS A CONSEQUENCE OF

(d) Decubitus Ulcer - Extensive

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

hours

hours

2 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-13-79 to 6-14-79, that (I) (we) last saw the deceased alive on 6-13-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

6-14-79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

NOR D. LIST

ADDRESS

GreenSpring &amp; Belvedere Ave (21215)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

JUNE 14, 1979

23c. NAME OF CEMETERY

LUBAWITZ NUSACH ARI

23d. LOCATION

CITY OR TOWN

ROSEDALE

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME SOL LEVINSON &amp; BROS., INC.

6010 REISTERSTOWN RD.

BALTO., MD 21215

25a. DATE REC'D. BY REGISTRAR

JUN 19 1979

25b. REGISTRAR'S SIGNATURE

L. H. Brady

9 4 3 4 1 4 3 4 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 5 5 0

|                                                                                                                   |                                                                                                                                   |                                                                                                                                                             |                                                                                      |                                                |                                                                |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOSEPH C. RADAWIEC                                       |                                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>June-14-79                                       |                                                | 2b. HOUR AM PM<br>6:35 PM                                      |
| 3. SEX<br>male                                                                                                    | 4. RACE<br>white                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02-12-17                                                                                                              |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MI                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD                            |                                                |                                                                |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTO GEN HOSP |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dundalk          |                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH STEEL                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. | 13b. COUNTY<br>Dundalk - Baltimore                                                                                                | 13c. CITY OR TOWN<br>Dundalk                                                                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>6711 2nd Ave. Md. 21222 |                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lawrence RADAWIEC                                                       |                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bobbi Anastesia                                                                                            |                                                                                      |                                                |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                  |                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>203 03 4421                                                                                                                     | 17. INFORMANT<br>Chart Copy - South Balto. gen. Hospital                             |                                                |                                                                |

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                      |                                                                                                                            |                                                |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                     |                                                                                      |                                                                                                                            |                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Diabetes mellitus; old cerebral thrombosis                                                                                                                                                                                             |                                                                                     |                                                                                      |                                                                                                                            |                                                |                                              |
| 19a. DATE OF OPERATION<br>6-13-79                                                                                                                                                                                                                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Temporary PACEMAKER-Heart block | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |                                                |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-9-1979 to 6-14-1979, that (we) lost<br>saw the deceased alive on 6-14-1979, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (he) (she) (it) (they) view the body after death.                                                                          |                                                                                     |                                                                                      |                                                                                                                            |                                                |                                              |
| 22b. SIGNATURE<br>V. ARDESHNA                                                                                                                                                                                                                                                                                                                                                  |                                                                                     | DEGREE                                                                               | 22c. DATE SIGNED<br>6-14-79                                                                                                |                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V. ARDESHNA, M.D.                                                                                                                                                                                                                                                                                                                     |                                                                                     | 22e. ADDRESS<br>South Baltimore general Hospital                                     |                                                                                                                            |                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                         | 23b. DATE<br>6-18-79                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                                                                     |                                                |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Weber                                                                                                                                                                                                                                                                                                                                  |                                                                                     | ADDRESS<br>401 S. Charles St                                                         | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979                                                                               | 25b. REGISTRAR'S SIGNATURE<br>Betty K. Kinsler |                                              |

BP

0 6 2 4 6 8 10





## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                         |                                                                                                                                                            |                                                                               |                                                                                                |                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>CORA Lee Randall                                                                                                                                                                                                                                                                                                                |                                                                                                                         |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>June 4 79                               |                                                                                                | 2b HOUR<br>11 P.M.                                                                                                        |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br>Black                                                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 12 24                                                                                                               |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                          |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                     | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                 | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a STATE<br>MD                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                         |                                                                                                                                                            | 13b COUNTY<br>Baltimore                                                       | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d STREET ADDRESS<br>4005 Belle Ave                                                                                      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Batler Lee                                                                                                                                                                                                                                                                                                                   |                                                                                                                         | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena Lee                                                                                                   |                                                                               |                                                                                                |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                 |                                                                                                                         | 16b SOCIAL SECURITY NO.<br>218-12-3894                                                                                                                     |                                                                               | 17 INFORMANT<br>Beatrice Lee ADDRESS same                                                      |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Metastatic terminal Ca of Colon<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                         |                                                                                                                                                            |                                                                               |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                    |                                                                                                                         |                                                                                                                                                            |                                                                               |                                                                                                |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                                                                                                         | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                              |                                                                                                                         | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                      |                                                                                                                         |                                                                                                                                                            |                                                                               |                                                                                                |                                                                                                                           |
| 22b SIGNATURE<br>Chung K. Park                                                                                                                                                                                                                                                                                                                                        |                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                                                                               | 22c DATE SIGNED<br>6/4/79                                                                      |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHUNG KIEL PARK                                                                                                                                                                                                                                                                                                               |                                                                                                                         | 22e ADDRESS                                                                                                                                                |                                                                               |                                                                                                |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                 |                                                                                                                         | 23b DATE<br>6- 8-79                                                                                                                                        |                                                                               | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                                           |                                                                                                                           |
| 23d LOCATION<br>CITY OR TOWN<br>Balto., Md.                                                                                                                                                                                                                                                                                                                           |                                                                                                                         | COUNTY                                                                                                                                                     |                                                                               | STATE                                                                                          |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br>Vernon Bailey F.H. 1348 Calhoun Street                                                                                                                                                                                                                                                                                                 |                                                                                                                         |                                                                                                                                                            |                                                                               | 25a DATE REC'D. BY REGISTRAR<br>JUN 7 1979                                                     |                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                         |                                                                                                                                                            |                                                                               | 25b REGISTRAR'S SIGNATURE<br>R. H. Bailey                                                      |                                                                                                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this form should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 5 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                       |                                                                                                                                                             |                                                                                                                            |                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH GEORGE RAUH</b>                                                                                                                                                                                                                                                                                                                                |                                                                                                                                       | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 14 1979</b>                                                                                                     |                                                                                                                            | 2b. HOUR<br>M                                                                                   |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>WHITE</b>                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 6 1913</b>                                                                                                   |                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>321 S. DUNCAN ST.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHEET METAL</b>                                         |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                       | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN RAUH</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA NEFF</b>                                                                                           |                                                                                                                            |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 05 7765</b>                                                         | 17. INFORMANT ADDRESS<br><b>MAGDALENE RAUH 321 S. DUNCAN ST.</b>                                                                                            |                                                                                                                            |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hypertension Cerebral Vascular Disease</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                       |                                                                                                                                                             |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                             |                                                                                                                                       |                                                                                                                                                             |                                                                                                                            |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                            |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                            |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/23</b> 19 <b>79</b> to <b>6/14</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5/17/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |                                                                                                                                       |                                                                                                                                                             |                                                                                                                            |                                                                                                 |
| 22b. SIGNATURE<br><b>Joseph B. Liberto</b>                                                                                                                                                                                                                                                                                                                                                   | DEGREE<br><b>MD</b>                                                                                                                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  | 22c. DATE SIGNED<br><b>6/15/79</b>                                                                                         |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH B. LIBERTO MD</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                       | 22e. ADDRESS<br><b>3508 BAY ST BALTIMORE, MD 21224</b>                                                                                                      |                                                                                                                            |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>6/16/79</b>                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS CEM</b>                                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                                                          |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RAYMOND L. KACZOROWSKI 2525 FLEET ST</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 21 1979</b>                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey M. Brady</b>                                                                      |                                                                                                 |

The medical examiner must be notified at once.

MEDICAL CERTIFICATION

1425

14



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 5 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna Teresa Raysinger                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 19, 1979                                            |                                                                                | 2b. HOUR<br>M                                                                                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 10, 1898                                                                                                         |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>139 E. Randall St. Balto. Md. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 13b. COUNTY                                                                                                                                | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>139 E. Randall St. Balto. Md.                           |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles ----- Puls                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dorothy ----- Rehman                                                                                       |                                                                                                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            | 16b. SOCIAL SECURITY NO<br>216-28-0230                                                                                                                      |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>Mrs. Mary E. Unger, 7799 High Point Rd. 21226      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASEVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u><br><u>SEVEN</u><br><u>4 HRS.</u> |                                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19                                                                                                                                                                                                                                                                                                        |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> , 19 <u>79</u> to <u>6/19</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                           |                                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><u>Jeffrey M. Pargament</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED<br>6/20/79                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JEFFREY M. PARGAMENT                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br>1211 Wall St. Balt. Md 21230                                   |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                            | 23b. DATE<br>June 23, 1979                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery                                       |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |
| 24. FUNERAL DIRECTOR<br>NAME<br>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                                                    |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby McBrady</u>                                                                          |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

0001-1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                        |                                                                                                                                                          |                                                                                                                                            |                                      |                                                                     |                 |                                                                |                 |                                              |     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------|-----------------|----------------------------------------------------------------|-----------------|----------------------------------------------|-----|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | FIRST                                                                  | MIDDLE                                                                                                                                                   | LAST                                                                                                                                       | 2a. DATE OF DEATH                    |                                                                     | MONTH           | DAY                                                            | YEAR            | 2b. HOUR                                     |     |
| LEONARD                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                        |                                                                                                                                                          | REAMER                                                                                                                                     | JUNE 4, 1979                         |                                                                     |                 |                                                                |                 | 9:30A                                        |     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE                                                                                                   |                                                                        | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                                                     | IF UNDER 1 YEAR |                                                                | IF UNDER 24 HRS |                                              |     |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                             | WHITE                                                                                                     |                                                                        | MONTH DAY YEAR<br>SEPT. 3, 1910                                                                                                                          |                                                                                                                                            | 68 YRS.                              |                                                                     | MONTHS DAYS     |                                                                | HOURS MIN.      |                                              |     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                     |                 |                                                                |                 |                                              |     |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                         | USA                                                                                                       |                                                                        |                                                                                                                                                          |                                                                                                                                            | BALTIMORE CITY                       |                                                                     |                 |                                                                |                 |                                              | MD. |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                         |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY    |                                                                     |                 |                                                                |                 |                                              |     |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                        | THE JOHNS HOPKINS HOSPITAL                                                                                |                                                                        | NIGHT WATCHMAN                                                                                                                                           |                                                                                                                                            | GLOBE SECURITY                       |                                                                     |                 |                                                                |                 |                                              |     |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                        |                                                                                                                                                          |                                                                                                                                            |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 13b. COUNTY                                                            |                                                                                                                                                          | 13c. CITY OR TOWN                                                                                                                          |                                      | 13d. INSIDE CITY LIMITS?                                            |                 | 13e. STREET ADDRESS                                            |                 |                                              |     |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                        |                                                                                                                                                          | BALTIMORE                                                                                                                                  |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 | 4809 ATHEA AVE. #21206                                         |                 |                                              |     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                        |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                                                                                                   |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| FIRST MIDDLE LAST<br>ISAAC REAMER                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                        |                                                                                                                                                          | FIRST MIDDLE LAST<br>BESSIE ISAACS                                                                                                         |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                        |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                                                                                                                   |                                      | 17. INFORMANT                                                       |                 | ADDRESS                                                        |                 | #21209                                       |     |
| YES                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                        |                                                                                                                                                          | WWI-ARMY                                                                                                                                   |                                      | THOMAS REAMER                                                       |                 | 2826 MARNAT RD., APT. C                                        |                 |                                              |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>possible hypertension</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>anemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>metastatic colonic carcinoma</u> |                                                                                                           |                                                                        |                                                                                                                                                          |                                                                                                                                            |                                      |                                                                     |                 |                                                                |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                        |                                                                                                                                                          |                                                                                                                                            |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                          |                                                                                                                                            |                                      | 20a. AUTOPSY?                                                       |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |                                              |     |
| 4/17/79                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | colonic carcinoma                                                      |                                                                                                                                                          |                                                                                                                                            |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |                                              |     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                            |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                     |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 22a. I certify that (this hospital) attended the deceased from <u>6/1</u> , 19 <u>79</u> , to <u>6/4</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/4</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                |                                                                                                           |                                                                        |                                                                                                                                                          |                                                                                                                                            |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                        |                                                                                                                                                          | DEGREE                                                                                                                                     |                                      |                                                                     |                 | 22c. DATE SIGNED                                               |                 |                                              |     |
| <u>Martha L. Elks</u>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                        |                                                                                                                                                          | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                      |                                                                     |                 | <u>6/4/79</u>                                                  |                 |                                              |     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                        |                                                                                                                                                          | 22e. ADDRESS                                                                                                                               |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| <u>Martha L. Elks</u>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                        |                                                                                                                                                          | <u>Johns Hopkins, Baltimore</u>                                                                                                            |                                      |                                                                     |                 |                                                                |                 |                                              |     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | 23b. DATE                                                              |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                 |                                                                |                 |                                              |     |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | JUNE 5, 1979                                                           |                                                                                                                                                          | BETH EL MEMORIAL PARK RANDALLSTOWN                                                                                                         |                                      | BALTO. MD                                                           |                 |                                                                |                 |                                              |     |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                        |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                      |                                                                     |                 | 25b. REGISTRAR'S SIGNATURE                                     |                 |                                              |     |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                        |                                                                                                                                                          | JUN 6 1979                                                                                                                                 |                                      |                                                                     |                 | <u>Patricia McCreedy</u>                                       |                 |                                              |     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

12021-1

NOTES

12021-1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 5 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |                                                                        |                                                                                                                                                            |                                                                    |                                                                                      |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EILEEN C. REEB                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 19 79                         |                                                                                                                                                            |                                                                    | 2b. HOUR<br>4:45 AM                                                                  |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 3 SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br>WHITE                                                                                                                |                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>09 29 04                                                                                                              |                                                                    | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                            |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                         |                                                       |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>IRELAND                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>IRELAND                                                                                        |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                            |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |                                                                        |                                                                                                                                                            |                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NURSES' AIDE     |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>BON SECOURS                                                                                           |                                                       |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MARYLAND                                                                                                                                                                                                                                                                                              |  |                                                                                                                                | 13b. COUNTY<br>BALTIMORE                                               |                                                                                                                                                            | 13c. CITY OR TOWN<br>BALTIMORE                                     |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br>530 S. CATHERINE STREET, 21223 |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PATRICK CAVANAUGH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MOLLY GANON           |                                                                                                                                                            |                                                                    |                                                                                      |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>214-18-3248A                               |                                                                                                                                                            | 17 INFORMANT<br>ADDRESS<br>GEORGE W. REEB, 530 S. CATHERINE STREET |                                                                                      |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Upper Gastrointestinal bleeding</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Polyp pre-pyloric area</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Electrolyte Imbalance</u> |  |                                                                                                                                |                                                                        |                                                                                                                                                            |                                                                    |                                                                                      |                                                                                                 |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><u>Polyphagia</u>                                                                                                                                                                                                                                                                |  |                                                                                                                                |                                                                        |                                                                                                                                                            |                                                                    |                                                                                      |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                       |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |  |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)       |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                     |  |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-10-79</u> to <u>6-19-79</u> , that (I) (we) last saw the deceased alive on <u>6-19-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                     |  |                                                                                                                                |                                                                        |                                                                                                                                                            |                                                                    |                                                                                      |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 22b. SIGNATURE<br><u>G. K. MacHotra</u>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |                                                                        |                                                                                                                                                            |                                                                    | DEGREE<br>M.D.                                                                       |                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                       | 22c. DATE SIGNED<br>6-19-79 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C.K. MACHOTRA                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |                                                                        |                                                                                                                                                            |                                                                    | 22e. ADDRESS<br>ST. Agnes Hospital, Baltimore                                        |                                                                                                 |                                                                                                                                            |                                                       |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                | 23b. DATE<br>06-22-79                                                  |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                |                                                                                      |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                                                                      |                                                       |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                | ADDRESS<br>21229 4107 WILKENS AVE.                                     |                                                                                                                                                            |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McBrady</u>                                                                                      |                                                       |                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



PLATE 11

PLATE 11

PLATE 11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 5 6  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                    |                                                                                                                                                             |                                                                                            |                                                                           |                                                                                      |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OTTO VINCENT Rethemeyer Sr.</b>            |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR <b>6 20 79</b>                                            |                                                                           | 2b. HOUR <b>3 PM</b>                                                                 |
| 3. SEX<br><b>Male</b>                                                             | 4. RACE<br><b>White</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5 17 12</b>                                                                                                           |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                                                                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLOTHING CUTTER</b> |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>                                 |
| 13a. STATE<br><b>MD</b>                                                           |                                                                                                                                    |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                            | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>OTTO VINCENT RETHEMEYER</b>          |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARMEN BARETO</b>                     |                                                                           |                                                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>216-05 8087</b>                                                                                                              |                                                                                            | 17. INFORMANT ADDRESS<br><b>Otto Vincent Rethemeyer, Jr., Balto., Md.</b> |                                                                                      |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**CARDIAC ARREST**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**15 min**

**4151**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **HYPERTENSION**

**5 hours**

DUE TO, OR AS A CONSEQUENCE OF

(c) **POSSIBLE PULMONARY EMBOLISM**

**5 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**② CORONARY ARTERY ACCIDENT 2/79 + 6/18/79**

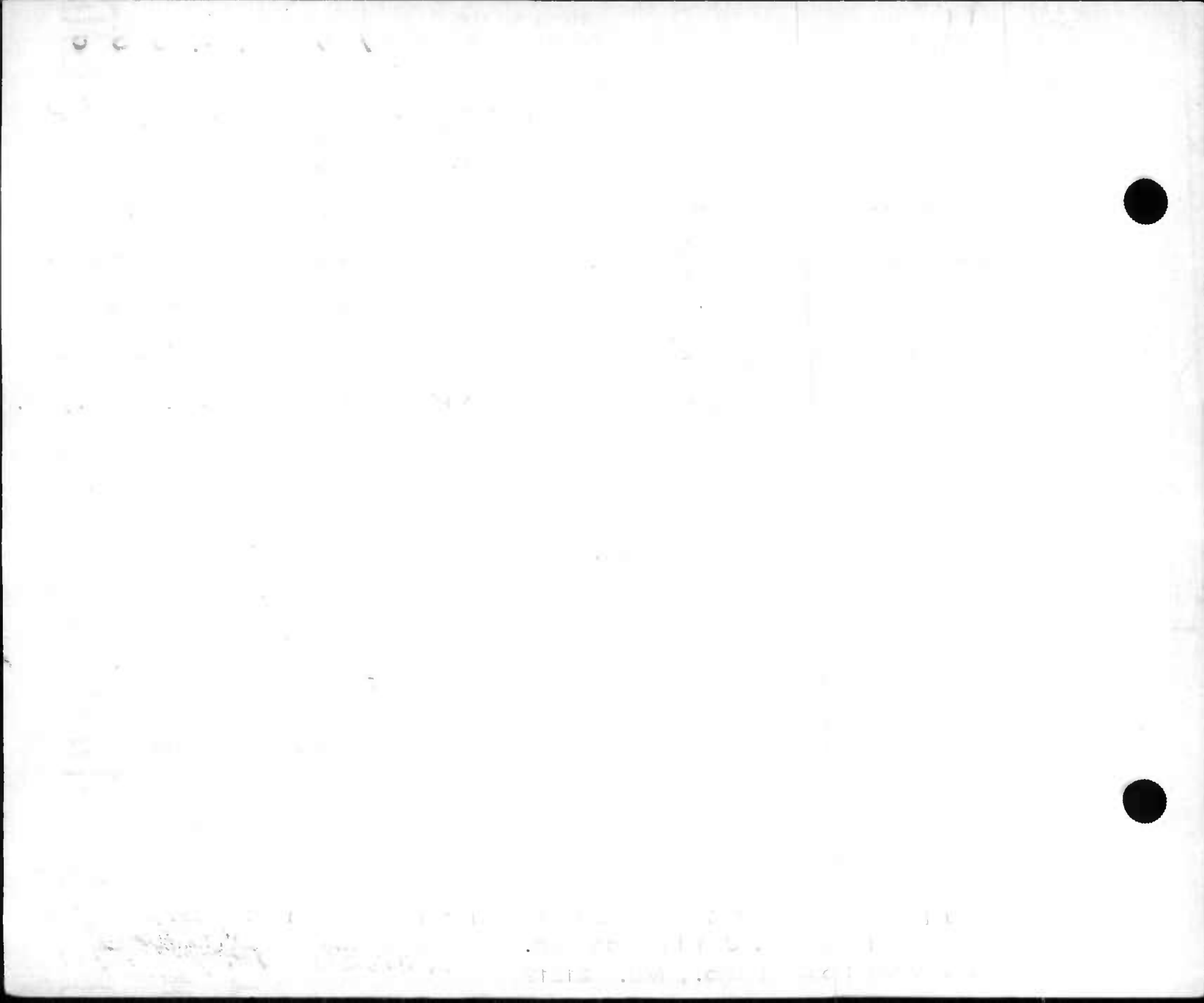
|                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                      |                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>8</b>                                                                                                                                                                                                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JUNE 18</b> , 19 <b>79</b> , to <b>JUNE 20</b> , 19 <b>79</b> , that (1) (we) last<br>saw the deceased alive on <b>JUNE 17</b> , 19 <b>78</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) not view the body after death. |                                                                        |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><b>Charles Paul</b>                                                                                                                                                                                                                                                                                                                                     |                                                                        | DEGREE<br><b>MD</b>                                                                  | 22c. DATE SIGNED<br><b>6-20-79</b>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES PAUL HOESCH</b>                                                                                                                                                                                                                                                                                                       |                                                                        | 22e. ADDRESS<br><b>7712 BECHAN RD.; BALTO. 21236</b>                                 |                                                                                                                               |

|                                                                  |                             |                                                                |                                                                              |
|------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>    | 23b. DATE<br><b>6-23-79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins Sons Co.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                             |
| 4905 York Road Balto., Md. 21212                                 |                             |                                                                |                                                                              |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 5 7

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                      |  |                                                                                                                            |                                   |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary D. REULING                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 24 1979                    |                                                                                                                                                             |                                                             | 2b. HOUR<br>A. M.                                                                                                                                    |  |                                                                                                                            |                                   |                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>Caucasian                                                                                                              |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 29, 1915                                                                                                         |                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64                                                                                                                |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.                                                                               |                                   |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                           |  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |                                                                        |                                                                                                                                                             |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                        |  |                                                                                                                            |                                   |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Baltimore                                                                                                          |                                                                        | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |  | 13e. STREET ADDRESS<br>216 S. Vincent St.                                                                                  |                                   |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John AHERN                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie FELL                                                                                                 |                                                             |                                                                                                                                                      |  |                                                                                                                            |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-20-2718                                                            |                                                                        | 17. INFORMANT<br>ADDRESS<br>216 S. Vincent St.<br>William U. M. Reuling Balto., Md. 21223                                                                   |                                                             |                                                                                                                                                      |  |                                                                                                                            |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a) or (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cordae Unrest</i><br>410- DUE TO, OR AS A CONSEQUENCE OF, <i>Cordae Unrest</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cordae Unrest</i><br>DUE TO, OR AS A CONSEQUENCE OF, <i>Cordae Unrest</i><br>(c) <i>Cordae Unrest</i> |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                      |  |                                                                                                                            |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Hypertension</i>                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                      |  |                                                                                                                            |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |  |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |                                   |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                 |  |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |                                   |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-11-2</i> 19 <i>71</i> to <i>5-15</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>5-11-2</i> 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.                                                                    |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                      |  |                                                                                                                            |                                   |                                              |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>6/25/79</i>                                                                                         |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIGUEL HEREDIA, M.D.                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             | 22e. ADDRESS<br>PRAVIA MEDICAL CENTER, 413 COMMONWEALTH                                                                                              |  |                                                                                                                            |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   | 23b. DATE<br>6-27-79                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park |                                                                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Co. Md.                                                        |                                   |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. Balto., Md. 21229                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |                                   |                                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SECURITY CLASSIFICATION

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Figure 2

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14558

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                    |  |                                                                                                                                                   |                                                      |                                                                                                                                                             |  |                                                                                                 |  |                                                                 |  |
|--------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAGGIE REYNOLDS</b>         |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-3-79</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>10 A.M.</b>                                                                      |  |                                                                 |  |
| 3. SEX<br><b>FEMALE</b>                                            |  | 4. RACE<br><b>BLACK</b>                                                                                                                           |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-29-01</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                       |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                         |  |                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHN L. DEATON MEDICAL CENTER</b> |                                                      |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. STATE<br><b>MARYLAND</b>                                      |  | 13b. COUNTY                                                                                                                                       |                                                      | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1144 Myrtle AVE</b>                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS MEANS</b>      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE HARRINGTON</b>                                                                         |                                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-7902</b>                                                  |  | 17. INFORMANT.<br>ADDRESS<br><b>HARRIET YOUNG 900</b>           |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

**Cerebrovascular accident,**

DUE TO, OR AS A CONSEQUENCE OF

**Extensive Decubiti**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

**Senility**

(c)

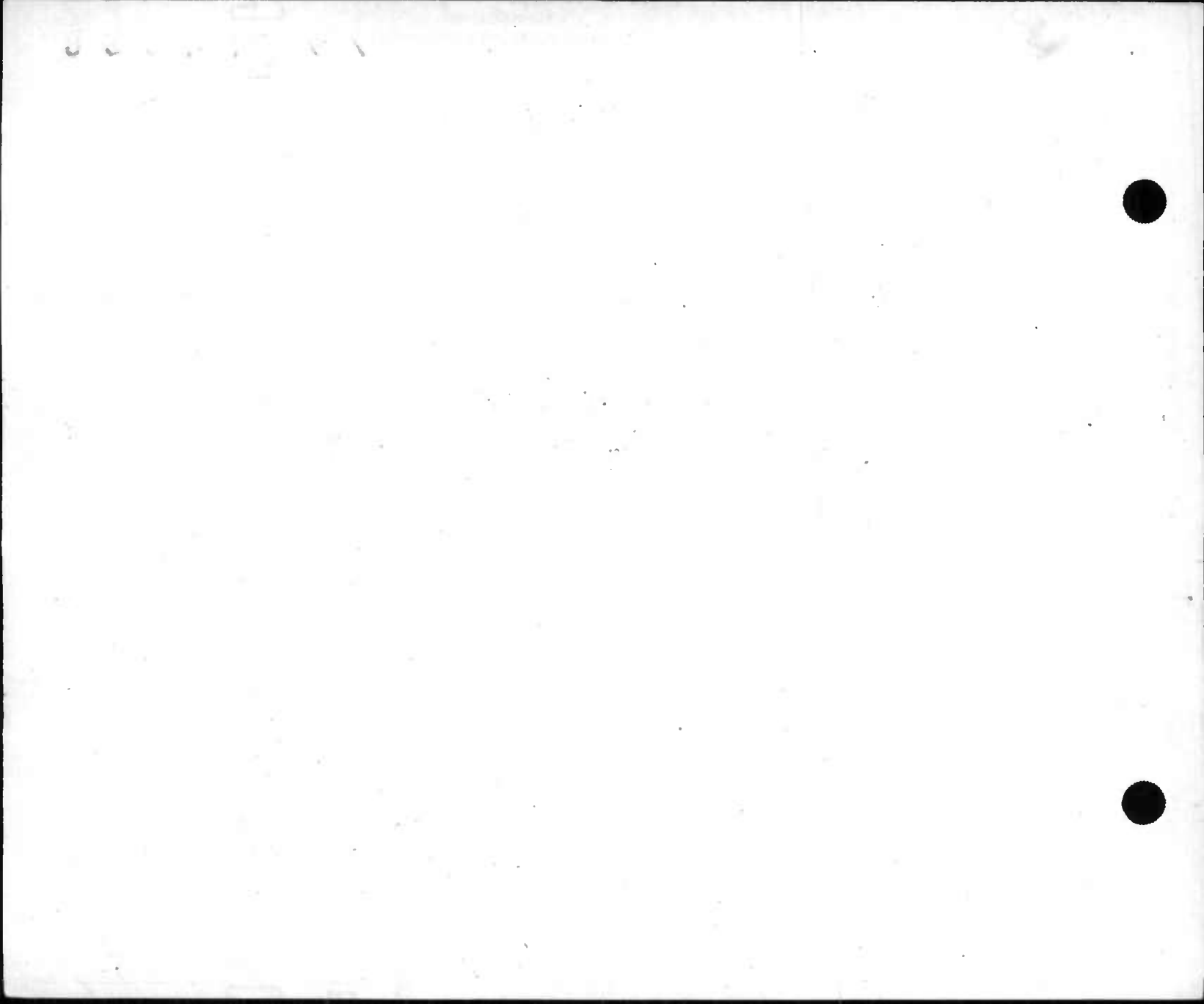
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-1-1979</b> to <b>6-3-1979</b> , that (I) (we) last<br>saw the deceased alive on <b>6-3-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | DEGREE<br><b>[Signature]</b>                                                   |  | 22c. DATE SIGNED<br><b>6/4/79</b>                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.S. SAWHNEY</b>                                                                                                                                                                                                                                                                          |  |                                                                        |  | 22e. ADDRESS<br><b>611 S. Charles St. Balto 21230</b>                          |  |                                                                                                                               |  |

|                                                               |  |                            |  |                                                       |  |                                                                         |  |
|---------------------------------------------------------------|--|----------------------------|--|-------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>6-9-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ARLINGTON S. Phillips</b>  |  |                            |  | ADDRESS<br><b>1721-27 N. Monmouth St.</b>             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.





Item 16b 6532 67/10/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 5 9

REG. NO

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               |                                                                         |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES THOMAS RICHMOND</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                        | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 23 79</b>                  |                                                                                                                                                            |                                                                               | 2b HOUR<br><b>9:15A M</b>                                               |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                               |  | 4 RACE<br><b>BLACK</b>                                                                                                                                 |                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 27 28</b>                                                                                                        |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b>                             |                                                                                                | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>    |                                                                                                                            |                                                 |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>                                                                                                                                                                                                                                                                                                  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                           |                                                                       | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD. |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |                                                                       |                                                                                                                                                            |                                                                               | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         |                                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                  |                                                                                                                            |                                                 |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                            |  |                                                                                                                                                        | 13b COUNTY                                                            |                                                                                                                                                            | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                          |                                                                         | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                    | 13e STREET ADDRESS<br><b>2521</b>                                                                                          |                                                 |  |
| 14 FATHER'S NAME<br><b>WALTER</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                        | MIDDLE<br><b>RICHMOND</b>                                             |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br><b>MATIE</b>                                       |                                                                         |                                                                                                | MIDDLE<br><b>McCoy</b>                             |                                                                                                                            | LAST                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                  |  | 16b SOCIAL SECURITY NO.<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KOREAN</b>                                                                 |                                                                       | 16c SOCIAL SECURITY NO.<br><b>60-24-9680</b>                                                                                                               |                                                                               | 17 INFORMANT<br>ADDRESS<br><b>VAMC CLINIC RECORDS BALTO., MD. 21218</b> |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br><b>1629 IMMEDIATE CAUSE (a) METASTATIC CANCER OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               |                                                                         |                                                                                                |                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>                                                               |                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:                                                                                                                                                                                                                                   |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               |                                                                         |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                               |                                                                         | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |                                                                                                                                                        | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                         |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                        |  |                                                                                                                                                        | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                         |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 22a I certify that (this hospital) attended the deceased from <b>JUNE 22, 1979</b> to <b>JUNE 23, 1979</b> , that (we) last saw the deceased alive on <b>JUNE 23, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                                       |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               |                                                                         |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 22b SIGNATURE<br><b>Matilda So MD.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               | DEGREE<br><b>MD.</b>                                                    |                                                                                                | 22c DATE SIGNED                                    |                                                                                                                            |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MATILDA SO</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               | 22e ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md 21218</b>            |                                                                                                |                                                    |                                                                                                                            |                                                 |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                        | 23b. DATE<br><b>6/29/79</b>                                           |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                 |                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>                     |                                                    |                                                                                                                            |                                                 |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                        |                                                                       |                                                                                                                                                            |                                                                               | ADDRESS<br><b>1101 E. North Ave.</b>                                    |                                                                                                | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b> |                                                                                                                            | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 returned by the hospital or attending physician.

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                    |  |                                                                                                                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BG <del>XXXXXXXX</del> RIEKEN                                                                                                                                                                                                                                                                                                                                                           |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 10 79                                                                                                     |  | 2b. HOUR<br>11 39 A M                                                                                                                                    |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 9 79                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>2 days                                                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>United States Md.                                                                                                                                                                                                                                                                                                                                                                                      |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                                                                                                                                                                                                                                                                                                                                                                                          |                  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Baltimore City Hospo                                                                          |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none                                                                                                                                                                                                                                                                                                                                                                               |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>none                                                                                                          |  | 13a. STATE<br>Maryland                                                                                                                                   |  |
| 13b. COUNTY<br>Ft                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13c. CITY OR TOWN<br>EASTON                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                          |  |
| 13e. STREET ADDRESS<br>114 Reliance Ave                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALLEN A. RIEKEN                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA M (XXXXXXXX) Miller                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                             |                  | 16b. SOCIAL SECURITY NO.<br>No                                                                                                                     |  | 17. INFORMANT<br>ADDRESS<br>G. Karlowicz MD BCH                                                                                                          |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiovascular arrest<br>769-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Severe Hyaline Membrane Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Severe Prematurity<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |                                                                                                                                                    |  |                                                                                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                    |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |                  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                                                                                                                      |                  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                  |  | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/9 1979, to 6/10 1979, that (I) (we) last saw the deceased alive on 6/10/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                         |                  |                                                                                                                                                    |  |                                                                                                                                                          |  |
| 22b. SIGNATURE<br>G. Karlowicz MD                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | DEGREE                                                                                                                                             |  | 22c. DATE SIGNED<br>6/10/79                                                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. KARLOWICZ                                                                                                                                                                                                                                                                                                                                                                                               |                  | 22e. ADDRESS<br>Baltimore City Hospo                                                                                                               |  | 22f. ADDRESS<br>Baltimore City Hospo                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 23b. DATE<br>6/13/79                                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                                                                                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland                                                                                                                                                                                                                                                                                                                                                                              |                  | 23e. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland                                                                             |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland                                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                |                  | ADDRESS<br>Catonsville, Md. 21228                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1979                                                                                                             |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 25c. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                          |  | 25d. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                |  |

BP

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MADE IN U.S.A.

(24)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the Store Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BERNARD F RITZ SR.                                                                                                                                                                                                                                       |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 13 1979                                  |                                                                                                 | 2b. HOUR<br>12:15 AM                                                                                                          |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                          | 4. RACE<br>W                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 10 1905                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS                                            |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS                                                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                                                 |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, FORMAL, MOST OF WORKING LIFE)<br>Pipe Fitter | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ditch Street                                               |                                                                                                                               |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                     |                                                                                                                                     | 13b. COUNTY<br>BALTO                                                                                                                                        | 13c. CITY OR TOWN                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>2730 Glenale Rd                                                                                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE RITZ                                                                                                                                                                                                                                                                |                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Quantmayer                                                                                          |                                                                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO                         |                                                                                                                               |
| 16b. SOCIAL SECURITY NO.<br>213-05-7588                                                                                                                                                                                                                                                                              |                                                                                                                                     | 17. INFORMANT<br>ADDRESS<br>Family Records                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARDIOGENIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) S/P OPEN-HEART SURGERY                                    |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 min<br>24 hours<br>36 hours                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                 |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |
| 19a. DATE OF OPERATION<br>6/11/79                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CORONARY ARTERY DISEASE                                                                                 |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                            |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                               |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/11 19 79 to 6/13 19 79, that (1) (we) lost<br>saw the deceased alive on 6/13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |
| 22b. SIGNATURE<br>Karl J. Karlson, MD                                                                                                                                                                                                                                                                                |                                                                                                                                     | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br>6/13/79                                                                     |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KARL J. KARLSON                                                                                                                                                                                                                                                             |                                                                                                                                     | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL                                                                                                                      |                                                                                      |                                                                                                 |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                               |                                                                                                                                     | 23b. DATE<br>6-16-79                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH                               |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                                                                        |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL                                                                                                                                                                                                                                                                 |                                                                                                                                     |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1979                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>Lester McCreedy                                                                                 |

MEDICAL CERTIFICATION

14302

(M)

George K. K. K.  
George K. K. K.  
George K. K. K.

George K. K. K.

George K. K. K.

George K. K. K.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 5 6 3

1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  |                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>AMELIA BUNGIN ROBERTS                                                                                                                                                                                                                                                                                                      |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 1, 1979                                                                                                   |  | 2b HOUR<br>10:45A                                                                                     |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>Negro                                                                                                                                      |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 15-1894                                                     |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.                                                                                                                                                                                                                                                                                                                                       |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL              |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                             |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic                                                                                                                                                                                                                                                                                                           |  | 12b KIND OF BUSINESS OR INDUSTRY<br>At Home                                                                                                          |  |                                                                                                       |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br>Balto.                                                                                                                                |  | 13c. CITY OR TOWN<br>Balto.                                                                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eddie                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Victoria Scott                                                                                      |  |                                                                                                       |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                             |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>26-74-2737                                                                                 |  | 17 INFORMANT<br>ADDRESS<br>Mrs. Doretha Cosby 281 S. Dallas Ct.                                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>sepsis</u><br>486-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>probable pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>degeneration</u> |  |                                                                                                                                                      |  |                                                                                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |  |                                                                                                       |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                      |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                              |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> , 19 <u>79</u> , to <u>6/1</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |                                                                                                                                                      |  |                                                                                                       |  |
| 22b. SIGNATURE<br>Martha L. Elks                                                                                                                                                                                                                                                                                                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>6/1/79                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Martha L. Elks                                                                                                                                                                                                                                                                                                                               |  | 22e ADDRESS<br>Johns Hopkins                                                                                                                         |  |                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>6-6-79                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>High Rock Cemetery                                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rice Prince Edward Va.                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                      |  |                                                                                                       |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Randolph J. Collick                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br>2431 E. Oliver St.                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Collick                                                                                                          |  |                                                                                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF TEXAS  
COUNTY OF DALLAS

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14564

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EILEEN P. ROBERTS                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 17 79                                                  |                                                                                | 2b. HOUR<br>3:01 PM                                                                                                        |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>WHITE                                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 17 35                                                                                                              |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSPITAL - B.C.R.C. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINE OPERA-              | 12b. KIND OF BUSINESS OR INDUSTRY<br>SOLO CUP CO.                              |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN LANSDOWNE                                                                                                                                                                                                                                                                                           |                                                                                                                                             |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>3233 TARTARIAN COURT, 21227                             |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MONROE JACKSON                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PEARL KUROWSKI                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>216-32-9525                                                                                                                     |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>WILLIAM F. ROBERTS, 3233 TARTARIAN COURT           |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac - Pulmonary Arrest</u><br>1919<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Globulostoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 minutes<br>4 years |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                        |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>79</u> , to <u>6/17/79</u> , that (I) (we) last saw the deceased alive on <u>6/17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                          |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><u>Konits</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                             | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br>6/17/79                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Philip Konits</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                             | 22e. ADDRESS<br><u>B.C.R.C.</u>                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE<br>06-21-79                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY                                                                                                  |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND          |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                                                                                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McBrady</u>                             |                                                                                                                            |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 6 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                  |                                                                                                                                                             |                               |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES Roberts                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>06 14 79 |                                                                                |                                                                           | 2b. HOUR<br>4:47AM                                                                                                                         |                                                                                                                            |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>Black                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 / 12 / 36                                                                                                          |                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.                                     |                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                             |                                                                                                                            | IF UNDER 24 HRS<br>HOURS MIN.                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ba lto.                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Ba lto. MD.                            |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>Ba lto.                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Ba lto. City Hosps. |                                                                                                                                                             |                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |                                                                                                                            |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                  |                                                                                                                                  | 13b. COUNTY                                                                                                                                                 |                               | 13c. CITY OR TOWN<br>Ba lto.                                                   |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                                                                            | 13e. STREET ADDRESS<br>2145 Vine St          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lenard Roberts                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Notis Taylor                                                                                               |                               |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>unk.                                                                                                                                                                                                                                                                                                                  |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>231 42 994                                                                                       |                               | 17. INFORMANT<br>ADDRESS<br>Mrs Annie Mae Roberts 2145 W. Vine St              |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5728 Intraabdominal bleeding with hypotension<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) Liver failure with ascites<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                  |                                                                                                                                                             |                               |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Chronic renal failure                                                                                                                                                                                                                                  |                                                                                                                                  |                                                                                                                                                             |                               |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                               |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                |                                                                                                                                  |                                                                                                                                                             |                               |                                                                                |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>J. Feldman, M.D.                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                  |                                                                                                                                                             |                               | DEGREE                                                                         |                                                                           | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br>6/14/79                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Feldman, M.D.                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                  |                                                                                                                                                             |                               | 22e. ADDRESS<br>Ba lto. City Hosps                                             |                                                                           |                                                                                                                                            |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                  | 23b. DATE<br>6-17-79                                                                                                                                        |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cem.                              |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Emporia Va.                                                                                  |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                  |                                                                                                                                                             |                               | ADDRESS<br>2222 W. North Ave                                                   |                                                                           | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                               |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>[Signature]    |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

20041 87



Handwritten notes at the top of the page, including the word "Hand" and "Notes".

Handwritten notes at the bottom of the page, including the word "Hand" and "Notes".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14566

|                                                                                                                                                                                                                      |         |                                                                  |                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------|-------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                   |         | FOR                                                              |                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                     |         | 2a. DATE KNOWN OF DEATH                                          |                   |
| SHAWN D. ROBERTSON                                                                                                                                                                                                   |         | x MONTH DAY YEAR 6 19 79                                         |                   |
| 3. SEX                                                                                                                                                                                                               | 4. RACE | 5. DATE OF BIRTH                                                 | 6. AGE (IN YEARS) |
| male                                                                                                                                                                                                                 | white   | 3 8 62                                                           | 17 YRS.           |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                            |         | 7c. CITIZEN OF WHAT COUNTRY?                                     |                   |
| Maryland                                                                                                                                                                                                             |         | U.S.A.                                                           |                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                            |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION         |                   |
| Baltimore                                                                                                                                                                                                            |         | 6207 Danville Ave.                                               |                   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                        |         | 12b. KIND OF BUSINESS OR SERVICE                                 |                   |
| Clerk                                                                                                                                                                                                                |         | Deputy & Market                                                  |                   |
| 13a. STATE                                                                                                                                                                                                           |         | 13b. COUNTY                                                      |                   |
| Maryland                                                                                                                                                                                                             |         | Baltimore                                                        |                   |
| 14. FATHER'S NAME                                                                                                                                                                                                    |         | 15. MOTHER'S MAIDEN NAME                                         |                   |
| Milton L. Robertson, Jr.                                                                                                                                                                                             |         | Nancy M. Orrell                                                  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                   |         | 16b. SOCIAL SECURITY NO.                                         |                   |
| No                                                                                                                                                                                                                   |         | 217-66-3563                                                      |                   |
| 17. INFORMANT                                                                                                                                                                                                        |         | 3740 Mt. Pleasant Ave.                                           |                   |
|                                                                                                                                                                                                                      |         | Carroll J. Starka-Balto. MD 21224                                |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                            |         |                                                                  |                   |
| PART I DEATH WAS CAUSED BY: Gunshot wound to the chest                                                                                                                                                               |         |                                                                  |                   |
| IMMEDIATE CAUSE (a) 9554                                                                                                                                                                                             |         |                                                                  |                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                       |         |                                                                  |                   |
| (b)                                                                                                                                                                                                                  |         |                                                                  |                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                       |         |                                                                  |                   |
| (c)                                                                                                                                                                                                                  |         |                                                                  |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                  |         |                                                                  |                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                               |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                |                   |
|                                                                                                                                                                                                                      |         |                                                                  |                   |
| 20. AUTOPSY?                                                                                                                                                                                                         |         |                                                                  |                   |
| YES x NO                                                                                                                                                                                                             |         |                                                                  |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING x OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                  |         | 21b. TIME OF INJURY 5:28 A.M. 6 MONTH 19 79                      |                   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                        |         | self-inflicted                                                   |                   |
| 21d. INJURY OCCURRED WHILE AT WORK x NOT WHILE AT WORK                                                                                                                                                               |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home |                   |
| 21f. LOCATION                                                                                                                                                                                                        |         | 6207 Danville Ave. Baltimore, Maryland                           |                   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy x, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide x, Homicide, Undetermined manner. |         |                                                                  |                   |
| ACTUAL SIGNATURE                                                                                                                                                                                                     |         | TITLE (SPECIFY)                                                  |                   |
| Margarita A. Korell                                                                                                                                                                                                  |         | Assistant                                                        |                   |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                      |         | DATE SIGNED                                                      |                   |
| Margarita A. Korell, M.D.                                                                                                                                                                                            |         | 6/20/79                                                          |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                            |         | 23b. DATE                                                        |                   |
| Burial                                                                                                                                                                                                               |         | 6/23/79                                                          |                   |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                   |         | 23d. LOCATION CITY OR TOWN                                       |                   |
| Oak Lawn Cemetery                                                                                                                                                                                                    |         | Baltimore, Baltimore, MD                                         |                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                            |         | 25a. DATE REC'D. BY REGISTRAR                                    |                   |
| Duda-Ruck, Inc.                                                                                                                                                                                                      |         | JUN 22 1979                                                      |                   |
| 7922 Wise Avenue, Dundalk, MD 21222                                                                                                                                                                                  |         | 25b. REGISTRAR'S SIGNATURE                                       |                   |
|                                                                                                                                                                                                                      |         | L. H. Kelly                                                      |                   |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14567

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|---------------------------------------------|--|
| 1- FOR REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                         |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH                                                           |  | 2b. HOUR                                                                         |  |                                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) CAUSEA CALANDUS ROBINSON                                                                                                                                                                                                                                                                                                                                                                                |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  | MONTH DAY YEAR 6 19 79                                                            |  | M 9:35                                                                           |  |                                             |  |
| 3. SEX male                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE negro |  | 5. DATE OF BIRTH MONTH DAY YEAR 2-19-09                                                                                   |  | 6. AGE (IN YEARS) 70 YRS                                    |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN.                                                       |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 19 79                                  |  |                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.                                                                                                                                                                                                                                                                                                                                                                                           |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                          |  |                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                           |  |                                                                                  |  |                                             |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2211 Ellamont St. |  |                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker                                                                               |  |                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |                                             |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                               |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                  |  | 13e. STREET ADDRESS 2211 N. Ellamont Street |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore                                                                                               |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elie Robinson                                                                                                                                                                                                                                                                                                                                                                                        |  |               |  |                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Pittman |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                                    |  |               |  | 16b. SOCIAL SECURITY NO. 213-07-4051                                                                                      |  | 17. INFORMANT Rocky Mount, N.C. Aline Howard 824 Beal St.,  |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |                                             |  |
| PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                      |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| IMMEDIATE CAUSE (a) 4292                                                                                                                                                                                                                                                                                                                                                                                                                 |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                         |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                      |  |                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                               |  |                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |                                                                                                                           |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |  |               |  | TITLE (SPECIFY) Assistant                                                                                                 |  |                                                             |  | MEDICAL EXAMINER                                                                                                                                         |  |                                                                                   |  | DATE SIGNED 6-19-79                                                              |  |                                             |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                       |  |               |  | ADDRESS 111 Penn St.                                                                                                      |  |                                                             |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                  |  |                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                         |  |               |  | 23b. DATE 6-23-79                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park         |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.                            |  |                                                                                  |  |                                             |  |
| 24. FUNERAL DIRECTOR NAME Wm C March                                                                                                                                                                                                                                                                                                                                                                                                     |  |               |  |                                                                                                                           |  | ADDRESS 1101 E. North Ave.                                  |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR JUN 21 1979                                         |  | 25b. REGISTRAR'S SIGNATURE                                                       |  |                                             |  |

14501



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 6 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                            |                                                                         |                                                                                                                                                                     |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN THOMAS ROBINSON</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 21 79</b>                    |                                                                                                                                                                     |  | 2b HOUR<br><b>12:08am</b>                                                                      |  |                                                                                                                           |                                         |                                                      |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br><b>BLACK</b>                                                                                                                                     |                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 06 16</b>                                                                                                                |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS                                                |  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>62</b>                                                                            |                                         | 7b IF UNDER 24 HRS<br>HOURS MIN<br><b>62</b>         |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                |  | 7c CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                         | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          |  | 9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY,</b> MD.                       |  |                                                                                                                           |                                         |                                                      |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |                                                                         |                                                                                                                                                                     |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |                                                                                                                           | 12b KIND OF BUSINESS OR INDUSTRY        |                                                      |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                |  | 13b COUNTY<br><b>BALTIMORE</b>                                                                                                                             |                                                                         | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>755 W. LEXINGTON STREET 21201</b>                                                                |                                         |                                                      |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>C. C. ROBINSON</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH OUTLAW</b> |                                                                                                                                                                     |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                          |  | 16b (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>                                                                                                             |                                                                         | 16c SOCIAL SECURITY NO.<br><b>224200314</b>                                                                                                                         |  | 17 INFORMANT<br><b>Ernest Robinson</b>                                                         |  |                                                                                                                           | 17 ADDRESS<br><b>2114 Braddish Ave.</b> |                                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Aspiration</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Aspiration carcinoma - metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                                            |                                                                         |                                                                                                                                                                     |  |                                                                                                |  |                                                                                                                           |                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Aspiration pneumonia</b>                                                                                                                                                                                                                          |  |                                                                                                                                                            |                                                                         |                                                                                                                                                                     |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
| 19a DATE OF OPERATION<br><b>6/25/79</b>                                                                                                                                                                                                                                                                                                                                                    |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aspiration pneumonia</b>                                                                             |                                                                         |                                                                                                                                                                     |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                         |                                                      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                    |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6 21 19 79</b>                                                                                        |                                                                         | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                       |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                         | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3900 LOCH RAVEN BLVD 21218</b>                                                                               |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
| 22a I certify that (this hospital) attended the deceased from <b>MAY 29</b> , 19 <b>79</b> , to <b>JUNE 21</b> , 19 <b>79</b> , that (I/we) lost<br>saw the deceased give an <b>X</b> <b>view the body after death</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated                                                                      |  |                                                                                                                                                            |                                                                         |                                                                                                                                                                     |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
| 22b SIGNATURE<br><b>Charles Newton</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                                                                         | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                |  | 22c DATE SIGNED<br><b>6-21-79</b>                                                                                         |                                         |                                                      |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Newton</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |                                                                         | 22e ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>                                                                                                                    |  |                                                                                                |  |                                                                                                                           |                                         |                                                      |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                               |  | 23b DATE<br><b>6/25/79</b>                                                                                                                                 |                                                                         | 23c NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                                        |  |                                                                                                |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>                                                          |                                         |                                                      |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                            |                                                                         | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                                |  |                                                                                                |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                                                        |                                         | 25b REGISTRAR'S SIGNATURE<br><b>History McCreedy</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be completed and attached.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 5 6 9

|                                                                                                                                                                                                                                                                                                                                                                                                          |                                           |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM A. ROBINSON</b>                                                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 15 1979</b>                                      |                                                                                     | 2b HOUR<br><b>1:25 A M</b>                                                                                                |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                     | 4 RACE<br><b>Black</b>                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 21 99</b>                                                                                                        |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                    |                                                                                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>                                                                                                                                                                                                                                                                                                                                                   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                             |                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b>              |                                                                                                | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                                                           |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                           | 13b CITY OR TOWN<br><b>Balto.</b>                                                                                                                          | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     | 13e STREET ADDRESS<br><b>510 Gold St.</b>                                                                                 |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Robinson</b>                                                                                                                                                                                                                                                                                                                                          |                                           | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Berdie</b>                                                                                              |                                                                                                |                                                                                     |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                             |                                           | 16b SOCIAL SECURITY NO.<br><b>A705-03-9365</b>                                                                                                             |                                                                                                | 17 INFORMANT ADDRESS<br><b>Sarah Robinson 510 Gold St.</b>                          |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY THROMBOEMBOLISM</b><br><b>4/51</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                           |                                           |                                                                                                                                                            |                                                                                                |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>METASTATIC ADENOCARCINOMA OF THE LUNG</b>                                                                                                                                                                                                                       |                                           |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |                                           | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |                                           | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |                                           | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                           |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 14 1979</b> , to <b>JUNE 15 1979</b> , that (I) (we) last saw the deceased alive on <b>JUNE 15 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |                                           |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                           |
| 22b SIGNATURE<br><b>Salvatore</b>                                                                                                                                                                                                                                                                                                                                                                        |                                           | DEGREE<br><b>JOSEPH SALVATORE M. D.</b>                                                                                                                    |                                                                                                | 22c DATE SIGNED<br><b>6/15/79</b>                                                   |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                     |                                           | 22e ADDRESS                                                                                                                                                |                                                                                                |                                                                                     |                                                                                                                           |
| <b>JOSEPH SALVATORE M. D.</b>                                                                                                                                                                                                                                                                                                                                                                            |                                           | <b>c/o MARYLAND GENERAL HOSPITAL</b>                                                                                                                       |                                                                                                |                                                                                     |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                |                                           | 23b DATE<br><b>6/21/79</b>                                                                                                                                 | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                                    |                                                                                     | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                        |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                     |                                           | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                       |                                                                                                | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                  | 25b REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>                                                                        |

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. TO EXECUTE THE CERTIFICATE, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME; PAGES 4 AND 5 TO THE COUNTY CLERK'S OFFICE. TO COMPLETE THE CERTIFICATE, RETURN PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS.

**PAGE 4** SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH: 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14570  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|--|---------------------------------------------------------------------------------------------------------|--|-------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-----------------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | FIRST   |  | MIDDLE                                                                                                  |  | LAST              |  | 20. DATE KNOWN OF DEATH                                                                                                                                  |  | ESTIMATED        |  | MONTH                                                                                        |  | DAY                                                                 |  | YEAR                              |  | 26. HOUR |  |
| Joe                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | L.      |  | Rogers                                                                                                  |  |                   |  | 6                                                                                                                                                        |  | 11               |  | 19                                                                                           |  | 79                                                                  |  |                                   |  |          |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE |  | 5. DATE OF BIRTH                                                                                        |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.                                                                                                                                           |  | IF UNDER 24 HRS. |  | 21. DATE PRONOUNCED DEAD                                                                     |  | MONTH                                                               |  | DAY                               |  | YEAR     |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Black   |  | 10 10 35                                                                                                |  | 42 YRS.           |  | MONTHS                                                                                                                                                   |  | DAYS             |  | HOURS                                                                                        |  | MIN                                                                 |  | 6                                 |  | 11 19 79 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                     |  |                                   |  |          |  |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |  | USA                                                                                                     |  |                   |  |                                                                                                                                                          |  |                  |  | Baltimore City, MD.                                                                          |  |                                                                     |  |                                   |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |                                                                                                                                                          |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |
| Baltimore City                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         |  | Johns Hopkins Hospital                                                                                  |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  | 13b. COUNTY                                                                                             |  |                   |  | 13c. CITY OR TOWN                                                                                                                                        |  |                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                     |  | 13e. STREET ADDRESS               |  |          |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |  |                                                                                                         |  |                   |  | Balto.                                                                                                                                                   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |                                                                     |  | 1632 E. Federal St.               |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  | 15. MOTHER'S MAIDEN NAME                                                                                |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  | FIRST MIDDLE LAST                                                                                       |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| Harry Rogers                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |         |  | Lucy Carver                                                                                             |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  | 16b. SOCIAL SECURITY NO.                                                                                |  |                   |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  |                                                                                                         |  |                   |  | Gracie Rogers 1632 E. Federal St.                                                                                                                        |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| IMMEDIATE CAUSE (a) <u>Gunshot wound to abdomen (handgun)</u>                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 9650 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.                                                                                                                                                                                                                                                                                                                                                                 |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| (b) _____ DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                             |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| (c) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                  |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  | 20. AUTOPSY?                                                        |  |                                   |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                       |  |         |  | 21b. TIME OF INJURY HOUR <u>3</u> P.M. <u>6</u> MONTH <u>11</u> DAY <u>79</u> YEAR                      |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                   |  | subject shot by assailant                                                                                                                                |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                    |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             |  |                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  | street                                                                                                  |  |                   |  | 1700 Blk. Elsworth St. Balto                                                                                                                             |  |                  |  | MD                                                                                           |  |                                                                     |  |                                   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , <u>Homicide</u> <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |  |                                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |  | TITLE (SPECIFY)                                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  | DATE SIGNED                                                                                  |  |                                                                     |  |                                   |  |          |  |
| <u>Ann M. Dixon</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |  | M.D. Assistant MEDICAL EXAMINER                                                                         |  |                   |  |                                                                                                                                                          |  |                  |  | 6/12/79                                                                                      |  |                                                                     |  |                                   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  | ADDRESS                                                                                                 |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  | 111 Penn St. Balto., MD.                                                                                |  |                   |  |                                                                                                                                                          |  |                  |  |                                                                                              |  |                                                                     |  |                                   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  | 23b. DATE                                                                                               |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                     |  |                                   |  |          |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |  | 6/16/79                                                                                                 |  |                   |  | Cedar Hill Cem.                                                                                                                                          |  |                  |  | Anne Arundel Co., Md.                                                                        |  |                                                                     |  |                                   |  |          |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  |                                                                                                         |  |                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  |                  |  | 25b. REGISTER SIGNATURE                                                                      |  |                                                                     |  |                                   |  |          |  |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  |                                                                                                         |  |                   |  | JUN 15 1979                                                                                                                                              |  |                  |  | <u>Wm C March</u>                                                                            |  |                                                                     |  |                                   |  |          |  |

01221



UNIT 1222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 7 1

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                         |                                                                                |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                      |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                         | 2b. HOUR                                                                       |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                            |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                         | 2b. HOUR                                                                       |                                   |
| LEONARD C. ROLLINS                                                                                                                                                                                                                                                                                                          |                                                                                                        | 6 22 79                                                                                                                                                  |                                                         | 5:05AM                                                                         |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                         | 7. IF UNDER 1 YEAR                                                             |                                   |
| MALE                                                                                                                                                                                                                                                                                                                        | BLACK                                                                                                  | 6 17 1910                                                                                                                                                | 69 YRS.                                                 | IF UNDER 24 HRS                                                                |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                    |                                                                                |                                   |
| Maryland                                                                                                                                                                                                                                                                                                                    | USA                                                                                                    |                                                                                                                                                          | BALTIMORE, MD.                                          |                                                                                |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. QUALIFICATION (TYPE OF OCCUPATION OR WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE                                                                                                                                                                                                                                                                                                                   | UNIVERSITY OF MARYLAND HOSPITAL                                                                        |                                                                                                                                                          | Not known                                               |                                                                                |                                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                       | 13d. INSIDE CITY LIMITS?                                                       | 13e. STREET ADDRESS               |
| Maryland                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          | Balto.                                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 3712 BOARMAN AVENUE 21215         |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                         | 16. SOCIAL SECURITY NO.                                                        |                                   |
| Lerner                                                                                                                                                                                                                                                                                                                      |                                                                                                        | Rollins                                                                                                                                                  |                                                         | 213 05 8063                                                                    |                                   |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                           |                                                                                                        | 17b. INFORMANT                                                                                                                                           |                                                         | 17c. ADDRESS                                                                   |                                   |
| Yes                                                                                                                                                                                                                                                                                                                         |                                                                                                        | Mrs. Mildred Rollins                                                                                                                                     |                                                         | 3712 Boorman Ave.                                                              |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                         |                                                                                |                                   |
| 436- DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                         |                                                                                |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Hypertension                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                         |                                                                                |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Competitive heart failure; COPD; Cardiac Arrhythmia; @PRR @FTA                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                         |                                                                                |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                         | 20a. AUTOPSY?                                                                  |                                   |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                         |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                        | P.M. 19                                                                                                                                                  |                                                         |                                                                                |                                   |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                        |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                         | 21f. LOCATION                                                                  |                                   |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                         | STREET CITY OR TOWN COUNTY STATE                                               |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from June 21, 19 79, to June 22, 19 79, that (I) (we) last saw the deceased alive on June 21, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                         |                                                                                |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                              |                                                                                                        | DEGREE                                                                                                                                                   |                                                         | 22c. DATE SIGNED                                                               |                                   |
| Anita Fu                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                         | 6/22/79                                                                        |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                         |                                                                                |                                   |
| ANITA FU                                                                                                                                                                                                                                                                                                                    |                                                                                                        | UNIV. OF MARYLAND HOSPITAL                                                                                                                               |                                                         |                                                                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION                                           | COUNTY                                                                         | STATE                             |
| Burial                                                                                                                                                                                                                                                                                                                      | 6-27-79                                                                                                | Ind. Nat. Mem. Park                                                                                                                                      | Laurel                                                  | md                                                                             |                                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                   | 25. DATE REC'D. BY REGISTRAR                                                                           |                                                                                                                                                          | 26. REGISTRAR'S SIGNATURE                               |                                                                                |                                   |
| Joseph L. Russ                                                                                                                                                                                                                                                                                                              | JUL 2 1979                                                                                             |                                                                                                                                                          | R. H. H. H. H.                                          |                                                                                |                                   |



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14572

1. FOR  
STATE  
REGISTRAR

|                                                                                 |                                                                                                                                 |                                                                                                                                                             |                                                                               |                                                                                                         |                                           |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CATHERINE - Roppelt |                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/ 26/ 79                              |                                                                                                         | 2b. HOUR<br>4:10P M                       |
| 3. SEX<br>Female                                                                | 4. RACE<br>Caucasian                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 29 10                                                                                                               |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69<br>IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, City MD                                       |                                           |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home |

|                  |  |  |                          |                                  |                                                                                                 |                                        |
|------------------|--|--|--------------------------|----------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------|
| 13a. STATE<br>MD |  |  | 13b. COUNTY<br>Baltimore | 13c. CITY OR TOWN<br>Catonsville | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>106 Melvin Ave. |
|------------------|--|--|--------------------------|----------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------|

|                                                               |  |  |                                                               |  |  |
|---------------------------------------------------------------|--|--|---------------------------------------------------------------|--|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John B. Chamberlain |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dora Lastner |  |  |
|---------------------------------------------------------------|--|--|---------------------------------------------------------------|--|--|

|                                                                            |                                                              |                                                                                 |
|----------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>- | 17. INFORMANT<br>2816 E. Madison Street<br>Elmer B. Chamberlain (brother) 21205 |
|----------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) ACUTE CARDIAC ARRYTHMIA<br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) HASCVD<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 yr |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
DIABETES

|                                |                                                  |                                                                                      |                                                                                                                            |
|--------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br>NONE | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                          |                                                            |                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|

|                                                                                                              |                                                                        |                                                   |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------|
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------|

22a. I certify that (I) (this hospital) attended the deceased from 1972 to 1979, that (I) (we) lost saw the deceased alive on 3/29/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

|                                       |                                                                                                                                                      |                               |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| 22b. SIGNATURE<br>M. K. Gallagher, MD | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>28 Jun 79 |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|

|                                                            |                                                    |
|------------------------------------------------------------|----------------------------------------------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MCGALLAGER, JR MD | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD 21229 |
|------------------------------------------------------------|----------------------------------------------------|

|                                                        |                      |                                                        |                                        |
|--------------------------------------------------------|----------------------|--------------------------------------------------------|----------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>6/30/79 | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith | 23d. LOCATION<br>Baltimore, COUNTY Md. |
|--------------------------------------------------------|----------------------|--------------------------------------------------------|----------------------------------------|

|                                                     |                                      |                                             |                                             |
|-----------------------------------------------------|--------------------------------------|---------------------------------------------|---------------------------------------------|
| 24. FUNERAL DIRECTOR<br>S. Murek Funeral Home, Inc. | 3331 Brehms Lane<br>Balto. Md. 21213 | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979 | 25b. REGISTRAR'S SIGNATURE<br>L. J. McElroy |
|-----------------------------------------------------|--------------------------------------|---------------------------------------------|---------------------------------------------|

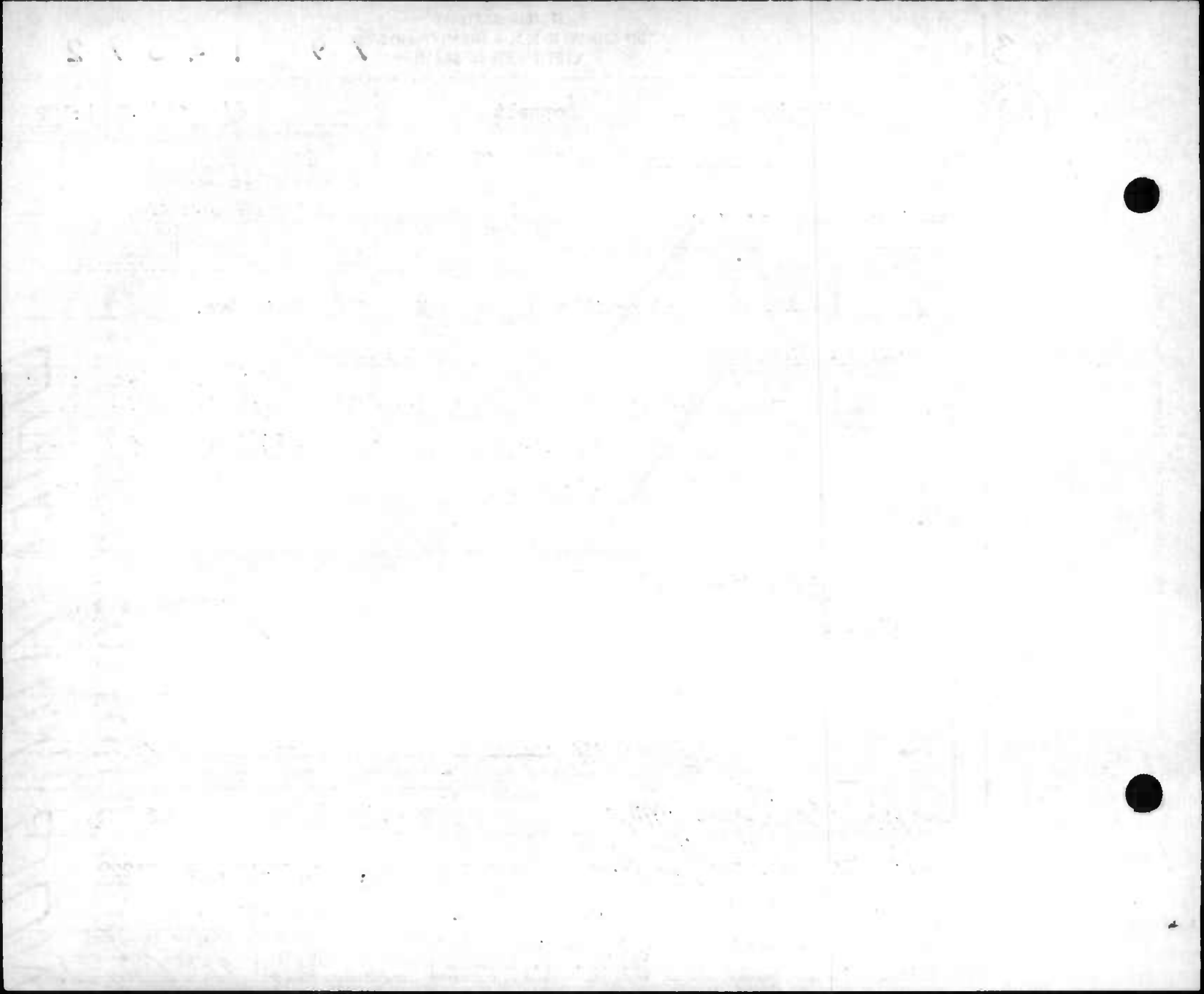
35 40 35 200 2  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

SECRET

CONFIDENTIAL



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 14573

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            |                                                                                                                                                                   |                                                                         |                                                                                                                            |                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth Rosenthal</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 12 1979</b>                |                                                                                                                                                             |                                                            | 2b. HOUR<br><b>6:30 AM</b>                                                                                                                                        |                                                                         |                                                                                                                            |                                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                                          |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 - 05 1888</b>                                                                                                   |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                                                                                                 |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York City</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Yes U.S.</b>                                                                                                                  |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                 |                                                                         |                                                                                                                            |                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>City Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Levindale Hebrew Geriatric Hosp &amp; Center</b> |                                                                           |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                              |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                        |                                                |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                                                     |                                                                           | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> XXX                                                               |                                                                         | 13e. STREET ADDRESS<br><b>Hennrichs House</b><br><b>133 Slade Avenue</b> #21208                                            |                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES MASHBACH</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JEANNETTE POLLACK</b> |                                                                                                                                                             |                                                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                    |                                                                         |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>215-48-4219</b> |  |
| 17. INFORMANT <b>MRS. JULIA GUGGENHEIM</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                  | 4. STONEHENGE CIR., APT. #1                                               |                                                                                                                                                             |                                                            | #21208                                                                                                                                                            |                                                                         |                                                                                                                            |                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, Acute, UNEXPLAINED</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CONGESTIVE CARDIAC FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CARDIAC DISEASE</b><br>YEARS |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            |                                                                                                                                                                   |                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b><br><b>24 hrs.</b>                                           |                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>GASTRIC ULCER WITH GI BLEEDING</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            |                                                                                                                                                                   |                                                                         |                                                                                                                            |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |                                                                                                                                                             |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                              |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |                                                                                                                                                             |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                    |                                                                         |                                                                                                                            |                                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                                                                                                                                                             |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                 |                                                                         |                                                                                                                            |                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/2</b> 19 <b>77</b> to <b>6/12</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/12</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                  |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            |                                                                                                                                                                   |                                                                         |                                                                                                                            |                                                |  |
| 22b. SIGNATURE<br><b>B. FAW-WIN</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                         | 22c. DATE SIGNED<br><b>6/12/79</b>                                                                                         |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. FAW-WIN</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            | 22e. ADDRESS<br><b>LEVINDALE GERIATRIC CENTER</b>                                                                                                                 |                                                                         |                                                                                                                            |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                  | 23b. DATE<br><b>JUNE 13, 1979</b>                                         |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. HEBREW</b> |                                                                                                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |                                                                                                                            |                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 Reisterstown Rd., Balto., MD 21215</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                  |                                                                           |                                                                                                                                                             |                                                            | 25a. DATE REC'D BY REGISTRAR<br><b>JUN 14 1979</b>                                                                                                                |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

BP

14218

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                            |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------|---------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                              |  |                                                                                                        | REG. NO. 9 1 4 5 7 4                                               |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  |                                                                                                        | FIRST MIDDLE LAST                                                  |                                                                                                                                                          |                                                                     | 2a DATE OF DEATH MONTH DAY YEAR                                               |                                                                  |                                                                     | 2b HOUR |
| JAMES                                                                                                                                                                                                                                                                                           |  |                                                                                                        | ROZANEK, JR.                                                       |                                                                                                                                                          |                                                                     | 6 21 79                                                                       |                                                                  |                                                                     | 3-00 PM |
| 3 SEX                                                                                                                                                                                                                                                                                           |  | 4 RACE                                                                                                 |                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)                                                |                                                                  | 7 IF UNDER 1 YEAR IF UNDER 24 HRS                                   |         |
| MALE                                                                                                                                                                                                                                                                                            |  | WHITE                                                                                                  |                                                                    | 05 08 21                                                                                                                                                 |                                                                     | 58 yrs. YRS                                                                   |                                                                  | MONTHS DAYS HOURS MIN.                                              |         |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                         |  | 9b CITIZEN OF WHAT COUNTRY?                                                                            |                                                                    | 8a MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                  |                                                                     |         |
| MARYLAND                                                                                                                                                                                                                                                                                        |  | U. S. A.                                                                                               |                                                                    |                                                                                                                                                          |                                                                     | BALTIMORE CITY MD.                                                            |                                                                  |                                                                     |         |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                    |                                                                                                                                                          |                                                                     | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                                                                  | 12b KIND OF BUSINESS OR INDUSTRY                                    |         |
| BALTIMORE CITY                                                                                                                                                                                                                                                                                  |  | SOUTH BALTIMORE GENERAL HOSPITAL                                                                       |                                                                    |                                                                                                                                                          |                                                                     | RETIRED                                                                       |                                                                  | GROGGER                                                             |         |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                     |  |                                                                                                        |                                                                    |                                                                                                                                                          | 13b INSIDE CITY LIMITS?                                             |                                                                               | 13c STREET ADDRESS                                               |                                                                     |         |
| 13a STATE CITY                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                    |                                                                                                                                                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                               | 6816, FT. SMALLWOOD ROAD. 21226                                  |                                                                     |         |
| MARYLAND BALTIMORE                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                    |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |                                                                               |                                                                  |                                                                     |         |
| JAMES ROZANEK                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                    |                                                                                                                                                          | MARY KREPELKA                                                       |                                                                               |                                                                  |                                                                     |         |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                    |  |                                                                                                        |                                                                    |                                                                                                                                                          | 16b SOCIAL SECURITY NO                                              |                                                                               | 17 INFORMANT ADDRESS                                             |                                                                     |         |
| YES                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                    |                                                                                                                                                          | WHITE 21598-7439                                                    |                                                                               | Pauline Falls 445 West Maple Rd. Baltimore, Md. 21201            |                                                                     |         |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                        |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 4449 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY INFARCT, PULMONARY FIBROSIS.                                                                                                                                                                                                                  |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                   |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| DUE TO, OR AS A CONSEQUENCE OF (c) THROMBOEMBOLY; Post RADIATION                                                                                                                                                                                                                                |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                              |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                           |  |                                                                                                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                                                     | 20a AUTOPSY?                                                                  |                                                                  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |         |
|                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |         |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                               |  |                                                                                                        | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |                                                                                                                                                          |                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                  |                                                                     |         |
|                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                           |  |                                                                                                        | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          |                                                                     | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                  |                                                                     |         |
|                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 22a I certify that (this hospital) attended the deceased from 05-18-1979, to 6-21-1979, that (we) lost saw the deceased alive on 6-21-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     |                                                                               |                                                                  |                                                                     |         |
| 22b SIGNATURE A. Sirithara                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     | DEGREE                                                                        |                                                                  | 22c DATE SIGNED 6/21/79.                                            |         |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mrs. ANUSHA SIRITHARA                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     | 22e ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL                                  |                                                                  |                                                                     |         |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                 |  |                                                                                                        | 23b DATE June 25, 1979                                             |                                                                                                                                                          | 23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.              |                                                                               | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Howard Co., Md. |                                                                     |         |
| 24 FUNERAL DIRECTOR NAME Mcully Funeral Home of Curtis Bay Balto., Md.                                                                                                                                                                                                                          |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                                                     | 25a DATE REC'D. BY REGISTRAR JUN 2 1979                                       |                                                                  | 25b REGISTRAR'S SIGNATURE [Signature]                               |         |

41241 87



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14575

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                    |  |                                                                                          |                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY EARL Ruff</b>                                                                                                                                                                                                                                                                                                                                                 |                        | 3a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 4 79</b>                                                                               |  | 3b. HOUR<br><b>6:25 AM</b>                                                               |                                                                                                 |
| 2. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>Col.</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 13 14</b>                                                                              |  | 6. AGE (IN YEARS) (LIST BIRTHDAY)<br><b>64</b>                                           |                                                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                               |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                         |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>                                                                                                                                                                                                                                                                                                                                                             |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired-clerk</b> |                                                                                                 |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                    |                        | 13b. COUNTY<br><b>-</b>                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                    |                                                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edgar M. Ruff</b>                                                                                                                                                                                                                                                                                                                                             |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie V. Canoles</b>                                                           |  | 16. STREET ADDRESS<br><b>1114 Weldon Avenue</b>                                          |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                         |                        | 16b. SOCIAL SECURITY NO.<br><b>212 03 3308</b>                                                                                     |  | 17. INFORMANT<br><b>Edna Mary Ruff Same</b>                                              |                                                                                                 |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>PULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PULMONARY EMBOLIA</b> |                        |                                                                                                                                    |  |                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MIN</b><br><b>5 HRS.</b><br><b>15 HRS.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>WIDESPREAD MALIGNANT DISEASE</b>                                                                                                                                                                                                                                |                        |                                                                                                                                    |  |                                                                                          |                                                                                                 |
| 19a. DATE OF OPERATION<br><b>DEC. 1978</b>                                                                                                                                                                                                                                                                                                                                                                 |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA STOMACH</b>                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                               |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5-25- 19 79</b>                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-25- 19 79</b> to <b>6-4 19 79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6-4- 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                                |                        |                                                                                                                                    |  |                                                                                          |                                                                                                 |
| 22b. SIGNATURE<br><b>Versteg</b>                                                                                                                                                                                                                                                                                                                                                                           |                        | DEGREE<br><b>M.D.</b>                                                                                                              |  | 22c. DATE SIGNED<br><b>6-4-79</b>                                                        |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VERSTEG</b>                                                                                                                                                                                                                                                                                                                                                    |                        | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>                                                                                              |  |                                                                                          |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                 |                        | 23b. DATE<br><b>6/6/79</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                        |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto. Md</b>                                                                                                                                                                                                                                                                                                                                  |                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                                 |  |                                                                                          |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>                                                                                                                                                                                                                                                                                                                   |                        | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McBrady</b>                                                                                |  |                                                                                          |                                                                                                 |

1990

1990-1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    |                                                                                                 |                                            |                                                                                                                            |  | REG. NO. 14576 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Baby Boy A (Sonia) RUSSELL                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 12 79                                                  |                                            | 2b. HOUR<br>721 P.M.                                                                                                       |  |                |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>black                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 12 79                                                                                                               |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>18                                        |                                            | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                                                        |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>United States                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                    |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |                                            |                                                                                                                            |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hosp |                                                                        |                                                                                                                                                             |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none                        |                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>none                                                                                  |  |                |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>Harford                                                                                                           |                                                                        | 13c. CITY OR TOWN<br>Abundun                                                                                                                                |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                            | 13e. STREET ADDRESS<br>HHC Aberdeen Prov Gd.                                                                               |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sonia — RUSSELL                                                                                            |                                    |                                                                                                 |                                            |                                                                                                                            |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |                                                                        | 16b. SOCIAL SECURITY NO.<br>—                                                                                                                               |                                    | 17. INFORMANT<br>ADDRESS<br>G. Karlowicz MD Baltimore City Hosp                                 |                                            |                                                                                                                            |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>769-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Hypotensive membrane disease<br>(c) Intracranial hemorrhage (probable).<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>18 hrs<br>2 hrs |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    |                                                                                                 |                                            |                                                                                                                            |  |                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    |                                                                                                 |                                            |                                                                                                                            |  |                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                    | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                            |                                                                                                                            |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                            |                                                                                                                            |  |                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 12, 1979, to June 12, 1979, that (I) (we) last saw the deceased alive on June 12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                               |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    |                                                                                                 |                                            |                                                                                                                            |  |                |  |
| 22b. SIGNATURE<br>G. Karlowicz MD                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    | DEGREE<br>MD                                                                                    |                                            | 22c. DATE SIGNED<br>6/12/79                                                                                                |  |                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. KARLOWICZ                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    | 22e. ADDRESS<br>Baltimore City Hosp.                                                            |                                            |                                                                                                                            |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>removal                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  | 23b. DATE<br>6/12/79                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                                                                            |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                    | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                                    |                                            | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy                                                                             |  |                |  |

BP

0101 28

MAINTENANCE  
OFFICE OF THE  
NAVY

101 1101

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                            |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|-------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                          |  | 7 9                                                                                                    |                                        | REG. NO. 14577                                                                                                                                           |                   |                                                                     |                                                                     |                                                                |                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                |  |                                                                                                        | 2a. DATE OF DEATH                      |                                                                                                                                                          |                   | MONTH DAY YEAR                                                      |                                                                     | 2b. HOUR                                                       |                         |  |
| FIRST MIDDLE LAST<br>Jody Bernard Rutkowski                                                                                                                                                                     |  |                                                                                                        | 6                                      |                                                                                                                                                          | 10 79             |                                                                     | 9 30 AM                                                             |                                                                |                         |  |
| 3. SEX                                                                                                                                                                                                          |  | 4. RACE                                                                                                |                                        | 5. DATE OF BIRTH                                                                                                                                         |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                                                     | IF UNDER 1 YEAR IF UNDER 24 HRS                                |                         |  |
| Male                                                                                                                                                                                                            |  | Caucasian                                                                                              |                                        | MONTH DAY YEAR<br>6 08 79                                                                                                                                |                   | YRS. MONTHS DAYS HOURS MIN.                                         |                                                                     |                                                                |                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                     |                                                                |                         |  |
| Maryland                                                                                                                                                                                                        |  | USA.                                                                                                   |                                        |                                                                                                                                                          |                   | Baltimore City MD.                                                  |                                                                     |                                                                |                         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                        |                                                                                                                                                          |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                              |                         |  |
| Baltimore                                                                                                                                                                                                       |  | Sinai Hosp                                                                                             |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| 13a. STATE                                                                                                                                                                                                      |  |                                                                                                        | 13b. COUNTY                            |                                                                                                                                                          | 13c. CITY OR TOWN |                                                                     | 13d. INSIDE CITY LIMITS?                                            |                                                                | 13e. STREET ADDRESS     |  |
| md                                                                                                                                                                                                              |  |                                                                                                        | Baltimore                              |                                                                                                                                                          | Baltimore         |                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                | 9740 Magleth Pd - 21234 |  |
| 14. FATHER'S NAME                                                                                                                                                                                               |  |                                                                                                        | 15. MOTHER'S MAIDEN NAME               |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| FIRST MIDDLE LAST<br>George Bernard Lohmuller, Jr.                                                                                                                                                              |  |                                                                                                        | FIRST MIDDLE LAST<br>Patrice Rutkowski |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                               |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                   |                                        | 17. INFORMANT                                                                                                                                            |                   | ADDRESS                                                             |                                                                     |                                                                |                         |  |
| No                                                                                                                                                                                                              |  |                                                                                                        |                                        |                                                                                                                                                          |                   | 21237 Rosamond Freeman 2000 Long View Ct.                           |                                                                     |                                                                |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                           |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| IMMEDIATE CAUSE (a) <u>Heart failure</u>                                                                                                                                                                        |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| 7798                                                                                                                                                                                                            |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe prematurity</u>                                                                                                                                                    |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                   |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                              |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                             |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                        |                                                                                                                                                          |                   | 20a. AUTOPSY?                                                       |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                         |  |
|                                                                                                                                                                                                                 |  |                                                                                                        |                                        |                                                                                                                                                          |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                              |  | 21b. TIME OF INJURY                                                                                    |                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                   |                                                                     |                                                                     |                                                                |                         |  |
|                                                                                                                                                                                                                 |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                        | 21f. LOCATION                                                                                                                                            |                   | CITY OR TOWN COUNTY STATE                                           |                                                                     |                                                                |                         |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                               |  |                                                                                                        |                                        | STREET                                                                                                                                                   |                   |                                                                     |                                                                     |                                                                |                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>79</u> , to <u>6/10</u> , 19 <u>79</u> , that (I) (we) lost                                                               |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| saw the deceased alive on <u>6/10</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |                                        |                                                                                                                                                          |                   |                                                                     |                                                                     |                                                                |                         |  |
| 22b. SIGNATURE                                                                                                                                                                                                  |  |                                                                                                        |                                        | DEGREE                                                                                                                                                   |                   | 22c. DATE SIGNED                                                    |                                                                     |                                                                |                         |  |
| <u>Birgitta Nilsson M.D.</u>                                                                                                                                                                                    |  |                                                                                                        |                                        |                                                                                                                                                          |                   | 6/10-79.                                                            |                                                                     |                                                                |                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                           |  |                                                                                                        |                                        | 22e. ADDRESS                                                                                                                                             |                   |                                                                     |                                                                     |                                                                |                         |  |
| BIRGITTA NILSSON                                                                                                                                                                                                |  |                                                                                                        |                                        | SINAI HOSP. PEDS. DEPT.                                                                                                                                  |                   |                                                                     |                                                                     |                                                                |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                       |  | 23b. DATE                                                                                              |                                        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                   | 23d. LOCATION                                                       |                                                                     |                                                                |                         |  |
| Burial                                                                                                                                                                                                          |  | June 12, '79                                                                                           |                                        | Parkwood Cemetery                                                                                                                                        |                   | Baltimore County, Md.                                               |                                                                     |                                                                |                         |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                            |  |                                                                                                        |                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                   | 25b. REGISTRAR'S SIGNATURE                                          |                                                                     |                                                                |                         |  |
| NAME ADDRESS<br>William E. Johnson 8521 Loch Raven Blvd                                                                                                                                                         |  |                                                                                                        |                                        | JUN 13 1979                                                                                                                                              |                   | <u>History McBrady</u>                                              |                                                                     |                                                                |                         |  |

UNITED STATES  
DEPARTMENT OF THE ARMY  
HEADQUARTERS



11 11 11

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which may be dates or references, but they cannot be accurately transcribed.]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14578

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |                                                              | 2b. HOUR                                                                       |                                  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                              | 2b. HOUR                                                                       |                                  |
| LUCILLE D. RUTTERS                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                              | June 13, 1979 7:00 P.M.                                                        |                                  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                            | 4 RACE                                                                                                 | 5 DATE OF BIRTH MONTH DAY YEAR                                                                                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.                                            |                                  |
| Female                                                                                                                                                                                                                                                                                                                                                           | White                                                                                                  | Feb. 28, 1909                                                                                                                                            | 70 YRS.                                                      | MONTHS DAYS HOURS MIN.                                                         |                                  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          | 9 CITIZEN OF WHAT COUNTRY?                                                                             | 10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                              | 11 BALTIMORE CITY OR COUNTY OF DEATH                                           |                                  |
| Florida                                                                                                                                                                                                                                                                                                                                                          | USA                                                                                                    |                                                                                                                                                          |                                                              | BALTIMORE CITY MD.                                                             |                                  |
| 12 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                         | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 15. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                        | UNION MEMORIAL HOSPITAL                                                                                |                                                                                                                                                          | Cashier                                                      |                                                                                | Hotel                            |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                      | 17a. STATE                                                                                             | 17b. COUNTY                                                                                                                                              | 17c. CITY OR TOWN                                            | 17d. INSIDE CITY LIMITS?                                                       | 17e. STREET ADDRESS              |
| Md.                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          | Balto.                                                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 402 Calvin Avenue                |
| 18 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 19 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                                |                                                              |                                                                                |                                  |
| Luter DeWitt                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | Belle Womble                                                                                                                                             |                                                              |                                                                                |                                  |
| 20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                |                                                                                                        | 20b. SOCIAL SECURITY NO.                                                                                                                                 |                                                              | 21 INFORMANT ADDRESS                                                           |                                  |
| No                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 262 16 0451                                                                                                                                              |                                                              | James L. Connolly Same                                                         |                                  |
| 22 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 5570                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>septic shock</u> ~ 16 hrs.                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>thrombosis of superior mesenteric artery</u> ~ 24 hrs.                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
| 23a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                              | 23c. AUTOPSY?                                                                  |                                  |
| 5/24, 5/26, 6/13                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | Exploratory Laparotomy                                                                                                                                   |                                                              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                  |
| 24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |                                                                                                        | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                              | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                  |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | P.M. 19                                                                                                                                                  |                                                              |                                                                                |                                  |
| 25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                         |                                                                                                        | 25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                              | 25c. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                  |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
| 26 I certify that (I) (this hospital) attended the deceased from <u>May 12</u> 19 <u>79</u> to <u>June 13</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                  |
| 27a. SIGNATURE                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | DEGREE                                                                                                                                                   |                                                              | 27b. DATE SIGNED                                                               |                                  |
| Paul Gertler M.D.                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                              | June 13, 1979                                                                  |                                  |
| 27c. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                            |                                                                                                        | 27d. ADDRESS                                                                                                                                             |                                                              |                                                                                |                                  |
| PAUL GERTLER M.D.                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | UNION MEMORIAL HOSPITAL                                                                                                                                  |                                                              |                                                                                |                                  |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                        | 28b. DATE                                                                                              | 28c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 28d. LOCATION CITY OR TOWN COUNTY STATE                      |                                                                                |                                  |
| Burial                                                                                                                                                                                                                                                                                                                                                           | 6-16-79                                                                                                | Moreland                                                                                                                                                 | Baltimore County, Md.                                        |                                                                                |                                  |
| 29 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 30. DATE REC'D. BY REGISTRAR                                                                                                                             | 31. REGISTRAR'S SIGNATURE                                    |                                                                                |                                  |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                     |                                                                                                        | JUN 18 1979                                                                                                                                              | [Signature]                                                  |                                                                                |                                  |

U.S. AIR FORCE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14579

|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                        |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                               | 2a. DATE OF DEATH MONTH DAY YEAR                                               |                                   | 2b. HOUR P                                                     |                                              |
| HUBERT PATRICK RYAN                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               | JUNE 17, 1979                                                                  |                                   | 4:20 M                                                         |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                     | 4. RACE                                                                                                | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                   | IF UNDER 1 YEAR IF UNDER 24 HRS                                |                                              |
| MALE                                                                                                                                                                                                                                                                                                                                                       | WHITE                                                                                                  | JUNE 18, 1902                                                                                                                                            |                                                               | 76 YRS                                                                         |                                   | MONTHS DAYS HOURS MIN.                                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                   |                                                                |                                              |
| CONNECTICUT                                                                                                                                                                                                                                                                                                                                                | USA                                                                                                    |                                                                                                                                                          |                                                               | BALTIMORE CITY MD.                                                             |                                   |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                |                                              |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                  | 1533 E. NORTHERN PARKWAY                                                                               |                                                                                                                                                          | CLERK                                                         |                                                                                | ST'D. OIL CO.                     |                                                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                             | 13d. INSIDE CITY LIMITS?                                                       | 13e. STREET ADDRESS               |                                                                |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          | BALTIMORE                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 1533 E. NORTHERN PARKWAY 39       |                                                                |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                     |                                   |                                                                |                                              |
| HUBERT WILLIAM RYAN                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               | MARY CASSIDY                                                                   |                                   |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                          |                                                                                                        | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)                                                                                                    |                                                               | 17. INFORMANT                                                                  |                                   | ADDRESS                                                        |                                              |
| YES                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | WW 11                                                                                                                                                    |                                                               | MRS. KATHRYNE GILL RYAN                                                        |                                   | SAME                                                           |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY?                                                                  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | P.M. 19                                                                                                                                                  |                                                               |                                                                                |                                   |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                     |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/4</u> 19 <u>77</u> , to <u>6/17</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               | DEGREE                                                                         |                                   | 22c. DATE SIGNED                                               |                                              |
| <u>Davis M. Hahn</u>                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               | MD                                                                             |                                   | <u>6/19/79</u>                                                 |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                               | 22e. ADDRESS                                                                   |                                   |                                                                |                                              |
| DAVIS M. HAHN, M.D.                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               | 5601 LOCH RAVEN BLVD. BALTO., MD.                                              |                                   |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 23b. DATE                                                                                                                                                |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | JUNE 20, 1979                                                                                                                                            |                                                               | DULANEY VALLEY MEM.                                                            |                                   | COCKEYSVILLE, BALTO MD.                                        |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | ADDRESS                                                                                                                                                  |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |                                              |
| MITCHELL-WIEDEFELD HOME, INC.                                                                                                                                                                                                                                                                                                                              |                                                                                                        | BALTO., MD.                                                                                                                                              |                                                               | JUN 21 1979                                                                    |                                   | <u>Hickory McCreedy</u>                                        |                                              |

1 2 3 4 5 6 7

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 1 4 5 8 0  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                            |                                                       |                                                                                         |                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NORMAN EDWARD RYAN</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 28 79</b> |                                                                                         | 2b. HOUR<br><b>10:00 PM</b> |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>WHITE</b>                                                                                                                                    |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 13 31</b>                                    |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                               |                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                           |                             |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                          |                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Truck Driver Trucking</b>                       |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |                             |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                            |                                                       | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                   |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Thomas Ryan</b>                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Almeda Divell</b>                                                                                      |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>      |                             |  |
| 16b. SOCIAL SECURITY NO.<br><b>212281756</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 17. INFORMANT<br><b>Ms Stephanie Goad</b>                                                                                                                  |                                                       | ADDRESS<br><b>640 5th Ave. Baltimore, Md 21227</b>                                      |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DIABETES MELLITUS</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                 |  |                                                                                                                                                            |                                                       |                                                                                         |                             |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Diabetic Renal Disease</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                                            |                                                       |                                                                                         |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                          |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |                             |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <b>MAY 15</b> 19 <b>79</b> , to <b>JUNE 28</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JUNE 28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |                                                                                                                                                            |                                                       |                                                                                         |                             |  |
| 22b. SIGNATURE<br><i>Richard Fastiggi</i>                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                                                                                                        |                                                       | 22c. DATE SIGNED                                                                        |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. FASTIGGI</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>                                                                                                          |                                                       |                                                                                         |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>7/2/79</b>                                                                                                                                 |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>                          |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Balto. Md</b>                                                                                                                                                                                                                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                         |                                                       | 25b. REGISTRAR'S SIGNATURE<br><i>Richard Fastiggi</i>                                   |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hwy. Balto.</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                            |                                                       |                                                                                         |                             |  |

U B C A I G I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                |  |  |  |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| Item #166 Film G535 9/25/79 re                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | STATE OF MARYLAND                                                                                                              |  |  |  |  |  |  |  |  |  |
| 1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Thomas Salmond                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 8 1979                                                                             |  |  |  |  |  |  |  |  |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 4 RACE<br>Negro                                                                                                                |  |  |  |  |  |  |  |  |  |
| 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 29 1929                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>49                                                                                           |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  |  |  |  |  |  |  |  |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                       |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine operator                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Coco Cola                                                                                 |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>---                                                                                                             |  |  |  |  |  |  |  |  |  |
| 13c. CITY OR TOWN<br>Baltimore                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Boykin Salmond                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Lewis                                                                   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>248-38-1292                                                                                        |  |  |  |  |  |  |  |  |  |
| 17 INFORMANT<br>Marie Salmond/901 Wicklow Rd./Balto. Md.                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | ADDRESS                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr                                                                           |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>2/79                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of colon                                                         |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |  |  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>early May 19 79</u> to <u>mid May 19 79</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |  |  |  |  |  |  |                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>William H. Howard</u>                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>6/11/79                                                                                                    |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William H. Howard                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>3300 N. Calver St., 21218                                                                                      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 23b. DATE<br>June 14, 1979                                                                                                     |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Balto. co. Maryland                                                      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL HOME<br>Name<br>Purnell B. Oden/4101 Edmondson Ave./Balto. Md.                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                                                                                   |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Purnell B. Oden</u>                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                |  |  |  |  |  |  |  |  |  |

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 1- FOR  
STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 5 8 2

|                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTHA E. SAMPSON</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-27-79</b>                                |                                                                                                 | 2b. HOUR<br><b>12:18am</b>                                                                                                 |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>W</b>                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 03 98</b>                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                     |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                       | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>ARBUTUS</b>                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1082 ELM ROAD, 21227</b>                                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>REINHOLT STRANZ</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELWIG UNKNOWN</b>                                                                                      |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                             |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br><b>215-30-8536</b>                                                                                                              |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>BETTY LOU BULL, 1082 ELM ROAD, 21227</b>                         |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarct</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>AS EVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                        |                                                                                                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                 |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                            |                                                                                                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Bert F. Morton, MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                          |                                                                                                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 | 22c. DATE SIGNED                                                                                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERT F. MORTON</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                       |                                                                                                                                                             | 22e. ADDRESS<br><b>ST AGNES HOSP.</b>                                                |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                       | 23b. DATE<br><b>06-29-79</b>                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.,</b>                                                                                                                                                                                                                                                                                                        |                                                                                                                                       | ADDRESS<br><b>4107 WILKENS AVE.</b>                                                                                                                         |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                             | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |

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 TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



WHITE CITY

STANDARD

WHITE

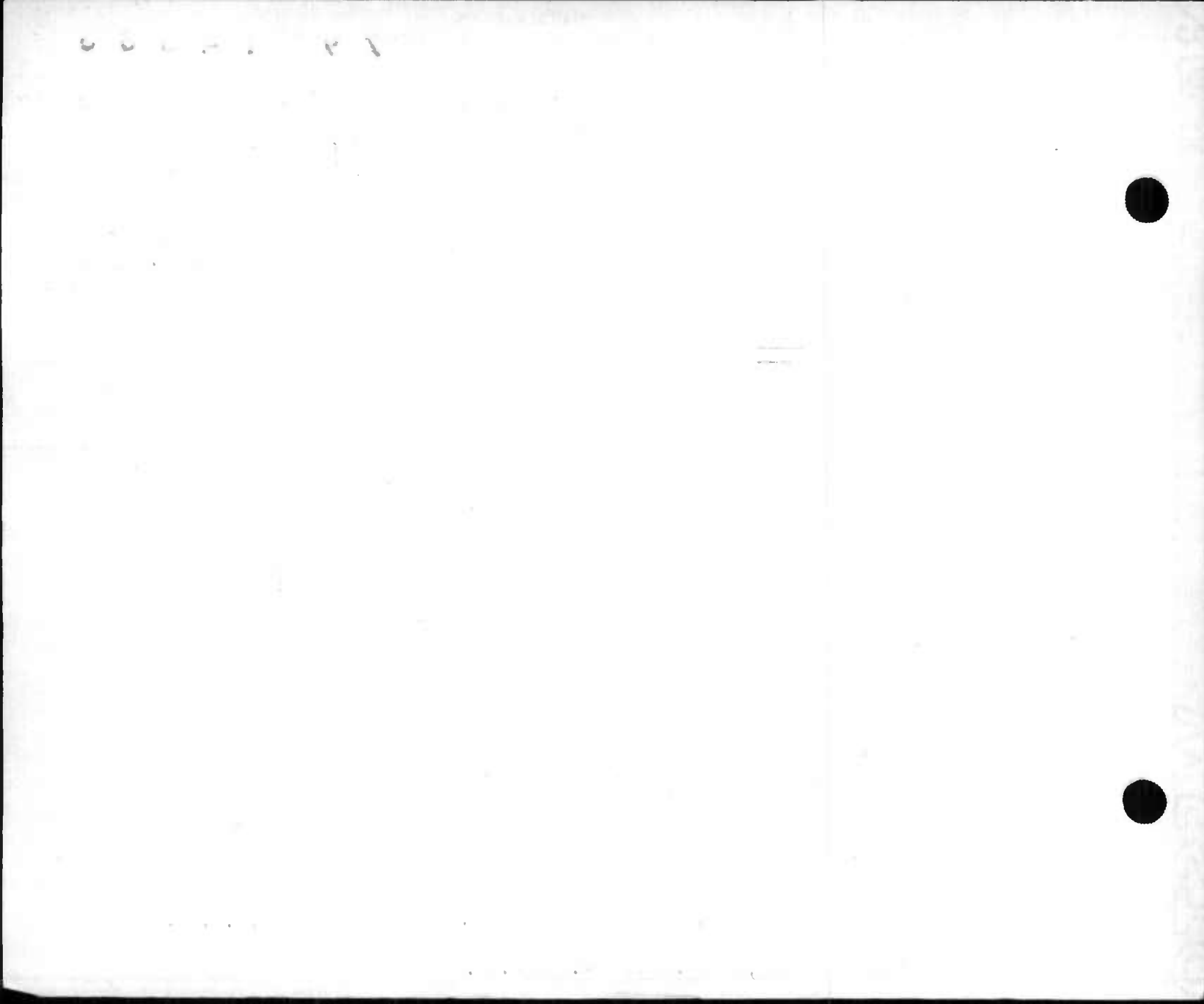


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14583

|                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            |                                                                                                                                                             |                                                                                                                            |                                                                    |                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                            | 2a. DATE OF DEATH                                                                                                                                           |                                                                                                                            | 2b. HOUR                                                           |                                                  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EDWARD CHARLES SCHEINER                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            | June-24-79                                                                                                                                                  |                                                                                                                            | 7:25 AM                                                            |                                                  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br>White                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06-02-98                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                  | 7c. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                                                |                                                                    |                                                  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. General Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Iron Worker                                            |                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. Drydock |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. 21230                                                                                                                                                                                                                                                                           | 13b. COUNTY<br>+                                                                                                                           | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS<br>824 - E. Fort Avenue<br>Balto. Md. 21230    |                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH SCHEINER                                                                                                                                                                                                                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna BLAZEK                                                                               |                                                                                                                                                             |                                                                                                                            |                                                                    |                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A                                                                                                                                                                                                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>212-09-9627                                                                                                    | 17. INFORMANT<br>ADDRESS<br>Chart Copy - S.B.G. Hospital                                                                                                    |                                                                                                                            |                                                                    |                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA and -</u><br>492-<br>DUE TO, OR AS A CONSEQUENCE OF <u>- Septicemia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Emphysema.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                            |                                                                                                                                                             |                                                                                                                            |                                                                    |                                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Basal cell carcinoma of nose; Peripheral vascular insufficiency.</u>                                                                                                                                                                                        |                                                                                                                                            |                                                                                                                                                             |                                                                                                                            |                                                                    |                                                  |
| 19a. DATE OF OPERATION<br>5-10-79                                                                                                                                                                                                                                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>By-pass Graft Shunt/stenosis                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |                                                  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                                            |                                                                    |                                                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                            |                                                                    |                                                  |
| 22a. I certify that (this hospital) attended the deceased from <u>4-27-1979</u> to <u>6-24-1979</u> , that (I) (we) lost<br>saw the deceased alive on <u>6-24-1979</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.                                                                       |                                                                                                                                            |                                                                                                                                                             |                                                                                                                            |                                                                    |                                                  |
| 22b. SIGNATURE<br><u>Sawerha</u>                                                                                                                                                                                                                                                                                                                                                                  | DEGREE<br>MD                                                                                                                               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br>6-24-79                                                                                                |                                                                    |                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V.R. ARDESHNA                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                            | 22e. ADDRESS<br>South Baltimore General Hospital                                                                                                            |                                                                                                                            |                                                                    |                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                               | 23b. DATE<br>June 27, 1979                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park                                                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, Md. Co. Maryland                                                |                                                                    |                                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                                                                                                                | 25b. REGISTRAR'S SIGNATURE<br><u>Marking</u>                                                                               |                                                                    |                                                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 5 8 4

|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |                                                                 |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIOLET L. SCHETTTLER</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 10, 1979</b>     |                                                                                                                                                             |                                       | 2b. HOUR<br>P<br><b>5:20</b>                                                                                                               |                                                                                                 |                                                                                                                            |                                                   |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>WHITE</b>                                                                                                             |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 12, 1922</b>                                                                                                  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>56</b>                                                                                        |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. MD</b>                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                     |                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                                                                          |                                                                                                 |                                                                                                                            |                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |                                                                 |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>                                                           |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STORE</b>                                                                          |                                                   |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     | 13b. COUNTY<br><b>—</b>                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>109 N. HIGHLAND AVE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-26-6274</b>                                                       |                                                                 | 17. INFORMANT<br><b>ERNEST SCHETTTLER</b>                                                                                                                   |                                       | ADDRESS <b>1132 MAPLE RD BALTO MD 21221</b>                                                                                                |                                                                                                 |                                                                                                                            |                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF SIGMOID COLON</b><br><b>1533</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                        |  |                                                                                                                                     |                                                                 |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                                 |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |                                                                 |                                                                                                                                                             |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>JUNE 8, 19 79</b> , to <b>JUNE 10, 19 79</b> , that (1) <input checked="" type="checkbox"/> was most saw the deceased alive on <b>JUNE 10, 19 79</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |                                                                                                                                     |                                                                 |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
| 22b. SIGNATURE<br><b>Paul E. Gormley MD</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |                                                                 | DEGREE<br><b>MD</b>                                                                                                                                         |                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6/10/79</b>                                                                                         |                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL E. GORMLEY, M.D.</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |                                                                 | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD</b>                                                                       |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>6-13 79</b>                                                                                                         |                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>                                                                                               |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CO MD.</b>                                                                         |                                                                                                 |                                                                                                                            |                                                   |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><b>POZDZINSKI FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>                                                                                                         |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                           |                                                                                                 |                                                                                                                            |                                                   |  |

100-51-11

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

(M)

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                           |  | REG. NO. 14585                                                                                                                                           |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HILDA SCHLOSS</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6 2 79</b> 2b. HOUR <b>9:30</b> A.M.                                                                              |  |                                                                                                                            |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>WHITE</b>                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>OCT. 11, 1907</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                                                                           |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                           |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                          |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>MEYER SCHLOSS</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>BIRDIE FRANK</b>                                                                                        |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>579-60-0797</b>                                            |  | 17. INFORMANT<br>ADDRESS <b>WASHINGTON, D.C.</b><br><b>IRVIN A. SCHLOSS 2700 CALVERT ST. NW.</b>                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESP. ARREST</b><br><b>514-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>BRONCHO PNEUMONIA.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PULMONARY CONGESTION.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4d.</b> |  |                                                                                           |  |                                                                                                                                                          |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Fracture R Hip</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                           |  |                                                                                                                                                          |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>5/27/79</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>fracture R Hip</b>                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> 19 <b>79</b> to <b>6/2</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                 |  |                                                                                           |  |                                                                                                                                                          |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Rein</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                           |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED<br><b>6/2/79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANKLIN REYES.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                           |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>6/3/79</b>                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW CEM</b>                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                           |  | 6010 REISTERSTOWN RD.<br><b>BALTIMORE, MD.</b>                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1979</b>                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>                                                                                                         |  |                                                                                                                            |  |

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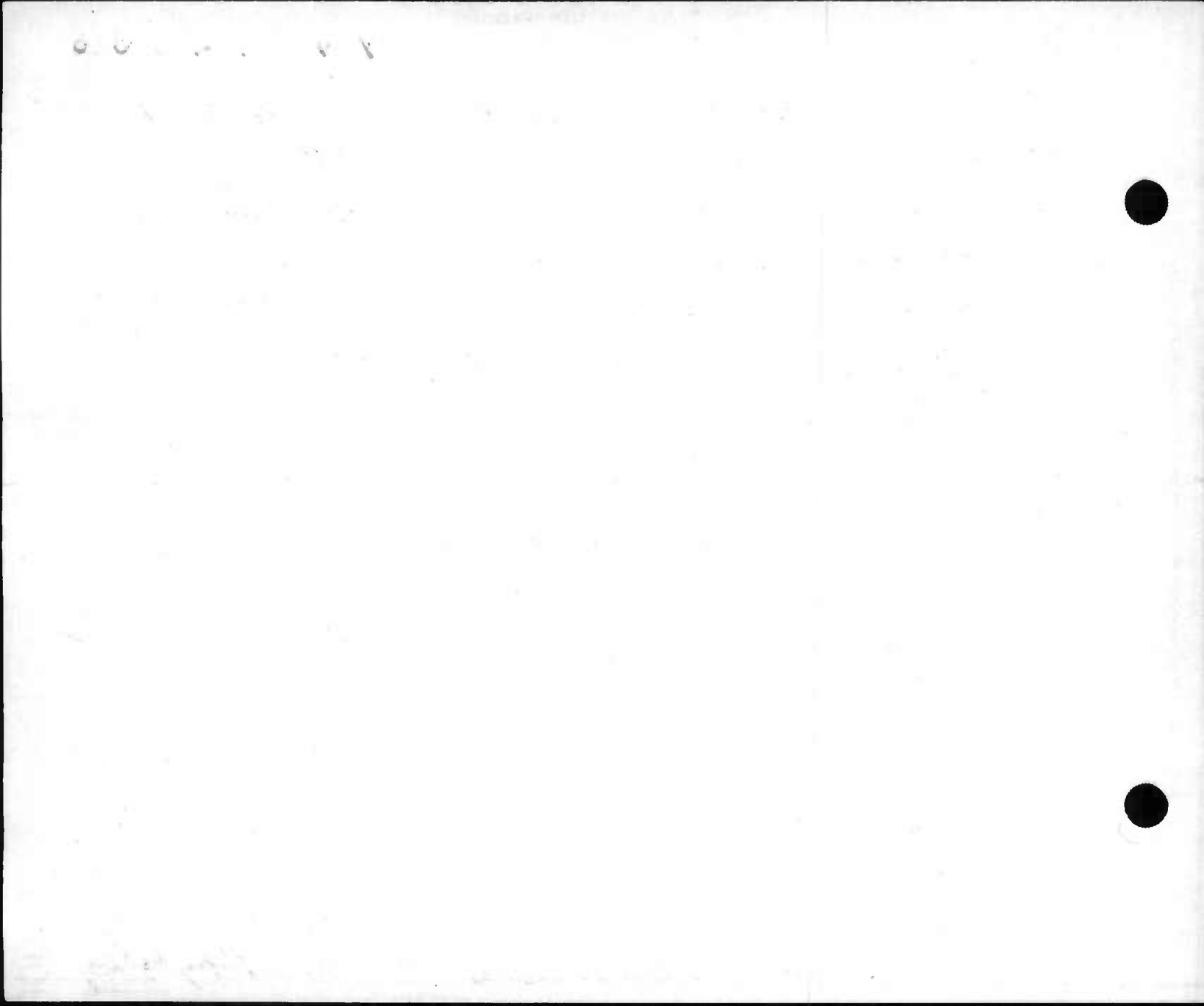
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 8 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Katherine Ann Schmick                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                     |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br>6 8 79                                    |                                                                                                | 2b HOUR<br>1206 P                                                                                                                    |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                   | 4 RACE<br>White                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 10 03                                                                                                               |                                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                                      | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>8 UNDER 28 HRS.<br>HOURS MIN.                                                                       |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                              | 7b CITIZEN OF WHAT COUNTRY?<br>C.S.A.                                                                                               | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                              | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                                                                                      |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                                                                                                     |
| 13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 13b COUNTY                                                                                                                                                 | 13c CITY OR TOWN<br>Baltimore                                                | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>1325 Cambria St. 21225                                                                                         |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Myerungs                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                     | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA Stewart                                                                                                |                                                                              |                                                                                                |                                                                                                                                      |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 16b SOCIAL SECURITY NO.                                                                                                                                    |                                                                              | 17 INFORMANT ADDRESS<br>Walter Schmick SAME AS 13e                                             |                                                                                                                                      |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>3989<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Rheumatic Heart Disease</u> |                                                                                                                                     |                                                                                                                                                            |                                                                              |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>Years</u><br><u>Years</u>                                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                                      |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                              | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |                                                                                                                                     | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                              | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                                      |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                       |                                                                                                                                     | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                              | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                      |
| 22a I certify that (I) (this hospital) attended the deceased from <u>May 31</u> , 19 <u>79</u> , to <u>June 8</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                           |                                                                                                                                     |                                                                                                                                                            |                                                                              |                                                                                                |                                                                                                                                      |
| 22b SIGNATURE<br><u>George J. Gonce</u>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                     | DEGREE                                                                                                                                                     |                                                                              | 22c DATE SIGNED<br>6/8/79                                                                      |                                                                                                                                      |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>George J. Gonce</u>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 22e ADDRESS<br><u>Univ of Maryland Hospital, Balto, Md</u>                                                                                                 |                                                                              |                                                                                                |                                                                                                                                      |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                             | 23b DATE<br>6/11/79                                                                                                                 | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery, Balto.                                                                                           |                                                                              | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Md.                                  |                                                                                                                                      |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>George J. Gonce 4001 Ritchie Highway                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                     | 25a DATE REC'D. BY REGISTRAR<br>JUN 14 1979                                                                                                                |                                                                              | 25b REGISTRAR'S SIGNATURE<br><u>R. J. H. H. H.</u>                                             |                                                                                                                                      |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               |                                                                                     |                                                                                                 |                                                                                                                                            |                                                       | REG. NO. 14587                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles A. Schmidt Sr.</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-23-79</b>                         |                                                                                     |                                                                                                 | 2b. HOUR<br><b>6:00 A</b>                                                                                                                  |                                                       |                                                                                                                                       |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 4 RACE<br><b>White</b>                                                                                                                        |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-5-1896</b>                                                                                                       |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                  |                                                       | IF UNDER 24 HRS<br>HOURS MIN.                                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4400 Asbury Avenue -21206</b> |                                                |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                                                                                        |                                                       |                                                                                                                                       |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               | 13b. COUNTY                                    |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Balto.</b>                                            |                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br><b>4400 Asbury Ave. -21206</b> |                                                                                                                                       |  |
| 14. FATHER'S NAME<br><b>Charles Schmidt</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br><b>Florence Jamison</b>                           |                                                                                     |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>216-01-4754</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Helen Schmidt 4400 Asbury Ave. -21206</b> |                                                                                     |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Disease - acute MI.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatoid Spondylitis.</b> |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               |                                                                                     |                                                                                                 |                                                                                                                                            |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               |                                                                                     |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               |                                                                                     |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>June 1, 1978</b> to <b>June 23, 1979</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                       |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               |                                                                                     |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Broad W. Linker MD</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               | DEGREE<br><b>MD</b>                                                                 |                                                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                       | 22c. DATE SIGNED<br><b>6/24/79</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               | 22e. ADDRESS                                                                        |                                                                                                 |                                                                                                                                            |                                                       |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 23b. DATE<br><b>6-26-79</b>                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>               |                                                                                     |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                                                            |                                                       |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd. -21206</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                |                                                                                                                                                             |                                                                               | ADDRESS                                                                             |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                        |                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                                                                                 |  |

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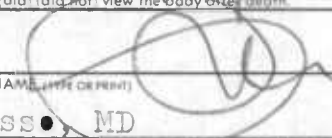
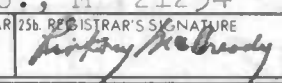
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 8 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         |                                                                                                                                                            |                                                                                                 |                                                                                                                     |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles A. SCHNEIDER                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 24, 1979                                            |                                                                                                                     | 2b. HOUR<br>M                                                                                                              |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                 | 4 RACE<br>Caucasian                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>March 4, 1922                                                                                                         |                                                                                                 | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                                   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                        |                                                                                                                     |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3815 Ridgescroft Rd. 21206 |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>metal worker                |                                                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                              | 13b. COUNTY<br>---                                                                                                                      | 13c. CITY OR TOWN<br>Baltimore                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3815 Ridgescroft Rd.                                                                         |                                                                                                                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward H. Schneider                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ma tilda Goetzke                                                                                           |                                                                                                 |                                                                                                                     |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                   | (IF YES, GIVE WAR OR DATES)<br>WW II                                                                                                    | 16b. SOCIAL SECURITY NO.<br>214-16-3025                                                                                                                    | 17 INFORMANT ADDRESS<br>Matilda Schneider, 3815 Ridgescroft 21206                               |                                                                                                                     |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                         |                                                                                                                                                            |                                                                                                 |                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                            |                                                                                                 |                                                                                                                     |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                     |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                   |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-12-79, 19, to 1-4, 1979, that (I) (we) last saw the deceased alive on 1-4-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                               |                                                                                                                                         |                                                                                                                                                            |                                                                                                 |                                                                                                                     |                                                                                                                            |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                                         |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                                                                                 | 22c. DATE SIGNED<br>25 June 79                                                                                      |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Russ, MD                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 22e. ADDRESS<br>5122 Harford Rd. 21214                                                                                                                     |                                                                                                 |                                                                                                                     |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial                                                                                                                                                                                                                                                                                                           | 23b. DATE<br>27 June 79                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood C emetery Balto., M                                                                                         |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>21234                                                                 |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ullrich Funeral Home, Balto., MD 21206                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                                                                                                               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br> |                                                                                                                            |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 5 8 9

|                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------------------|--|-----------------------------------|--|--------|--|------|--|-------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                 |  | FIRST                                                                                                  |  | MIDDLE                                                                                |  | LAST                                                                |  | 2a. DATE OF DEATH                                           |  |                                   |  | MONTH  |  | DAY  |  | YEAR  |  | 2b. HOUR |  |
| Samuel                                                                                                                                                                                                              |  | Schneider                                                                                              |  |                                                                                       |  |                                                                     |  | 6/6/79                                                      |  |                                   |  |        |  |      |  |       |  | 7:45 M   |  |
| 3. SEX                                                                                                                                                                                                              |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                             |  | IF UNDER 24 HRS                   |  | MONTHS |  | DAYS |  | HOURS |  | MIN.     |  |
| Male                                                                                                                                                                                                                |  | White                                                                                                  |  | 10 - 09 - 1895                                                                        |  | 83                                                                  |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 12a. PLACE OF DEATH (TYPE OF HOME OR PLACE OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |        |  |      |  |       |  |          |  |
| Md                                                                                                                                                                                                                  |  | U.S.                                                                                                   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | City Baltimore MD                                                   |  | XXXXXXX                                                     |  | CLOTHING                          |  |        |  |      |  |       |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | HEBREW HOME                                                                           |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| Balti                                                                                                                                                                                                               |  | Levinale                                                                                               |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                        |  | 13b. STATE                                                                                             |  | 13c. COUNTY                                                                           |  | 13d. CITY OR TOWN                                                   |  | 13e. INSIDE CITY LIMITS?                                    |  | 13f. STREET ADDRESS               |  |        |  |      |  |       |  |          |  |
| Md                                                                                                                                                                                                                  |  |                                                                                                        |  | Balti                                                                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                             |  | 6504 Armstrong Ave                |  |        |  |      |  |       |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?                                           |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT                                               |  |                                   |  |        |  |      |  |       |  |          |  |
| HERMAN                                                                                                                                                                                                              |  | RACHAEL                                                                                                |  | YES                                                                                   |  | 213-03-8220                                                         |  | MRS. SARA SCHNEIDER                                         |  |                                   |  |        |  |      |  |       |  |          |  |
|                                                                                                                                                                                                                     |  | UNKNOWN                                                                                                |  |                                                                                       |  |                                                                     |  | 6504 ARMSTONG AVE. #21215                                   |  |                                   |  |        |  |      |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY:                                                                                                                       |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF                                                        |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | DUE TO, OR AS A CONSEQUENCE OF                              |  |                                   |  |        |  |      |  |       |  |          |  |
| 410-                                                                                                                                                                                                                |  | Acute Gastrointestinal Bleeding                                                                        |  | Myocardial Infarction - CHD                                                           |  | Atherosclerotic Heart Disease                                       |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
|                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                 |  | Chronic Obstructive Pulmonary Disease                                                                  |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
|                                                                                                                                                                                                                     |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                  |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
|                                                                                                                                                                                                                     |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                |  | 21e. PLACE OF INJURY                                                                                   |  | 21f. LOCATION                                                                         |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>                                                                                                                                               |  | AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.                                                           |  | STREET                                                                                |  | CITY OR TOWN                                                        |  | COUNTY                                                      |  | STATE                             |  |        |  |      |  |       |  |          |  |
| 22a. I certify that this hospital attended the deceased from 5/31/79 to 6/6/79 that I saw the deceased alive on 6/6/79 and that in my opinion death occurred on the date and hour and from the causes stated above. |  |                                                                                                        |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 22b. SIGNATURE                                                                                                                                                                                                      |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                  |  | 22d. ADDRESS                                                                          |  | 22e. DATE SIGNED                                                    |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| [Signature]                                                                                                                                                                                                         |  | NOAL D. LIST                                                                                           |  | Greengrove Bethesda Av 2215                                                           |  | 6/6/79                                                              |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                           |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                    |  | 23d. LOCATION                                                       |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| BURIAL                                                                                                                                                                                                              |  | JUNE 7, 1979                                                                                           |  | CHIZUK AMUNO                                                                          |  | BALTIMORE                                                           |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                           |  | 25. DATE REC'D. BY REGISTRAR                                                                           |  | 25b. REGISTRAR'S SIGNATURE                                                            |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| SOL LEVINSON & BROS., INC.                                                                                                                                                                                          |  | JUN 13 1979                                                                                            |  | [Signature]                                                                           |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                             |  |                                                                                                        |  |                                                                                       |  |                                                                     |  |                                                             |  |                                   |  |        |  |      |  |       |  |          |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 5 9 0

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                      |                                                                              |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RAYMOND W. SCHOENEMAN</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 09 79</b>                 |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>5:18P M</b>                                                                                                           |                                                                              |                                                                                                                            |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>WHITE</b>                                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 29 30</b>                                                                                                       |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.                                                                                    |                                                                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                    |                                                                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL -- E.R.</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRAFFIC MGR.</b>                                              |                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MERCHANTS</b>                                                                      |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>A.A.</b>                                                                                                                     |                                                                        | 13c. CITY OR TOWN<br><b>LINTHICUM</b>                                                                                                                       |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |                                                                              | 13e. STREET ADDRESS<br><b>TERMINAL CORP.<br/>429 W. MAPLE ROAD, 21090</b>                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DONALD SCHOENEMAN HGTS.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>THELMA REED</b>    |                                                                                                                                                             |                                                                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                        |                                                                              |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-28-8797</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                | 17. INFORMANT<br><b>CAROLYN J. SCHOENEMAN</b>                          |                                                                                                                                                             |                                                                                | ADDRESS<br><b>LINTHICUM HGTS. MD.<br/>429 W. MAPLE RD.</b>                                                                           |                                                                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                      |                                                                              |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                 |                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/31</b> 19 <b>68</b> , to <b>6/9</b> 19 <b>79</b> , that (I) (we) most saw the deceased alive on <b>6/9</b> 19 <b>79</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated                                                                                                                                                         |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 21f. SIGNATURE<br><b>Herbert J. Lewickas</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                | DEGREE<br><b>M.D.</b>                                                  |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> |                                                                              | 22c. DATE SIGNED<br><b>6/11/79</b>                                                                                         |  |
| 21g. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERBERT J. LEWICKAS, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                | 22e. ADDRESS<br><b>5404 EAST DRIVE, ARBUTUS, MD. 21227</b>             |                                                                                                                                                             |                                                                                |                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                | 23b. DATE<br><b>06-13-79</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>                     |                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.,</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                | ADDRESS<br><b>4107 WILKENS AVE.</b>                                    |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                                                                  |                                                                              | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzroy Melroby</b>                                                                       |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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U. S. A. 1 1 1

UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
HEADQUARTERS, WASHINGTON, D. C.



| NO. | NAME | GRADE | COMPONENT | DATE |
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14591

1. FOR  
STATE  
REGISTRAR

|                                                                                                                   |                                                                                                                              |                                                                                                                                                             |                                                 |                                                                                 |  |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ASKER E-V. SCHULTZ                                                         |                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 16 79 |                                                                                 |  | 2b. HOUR<br>6:30AM                                                                              |  |
| 3. SEX<br>M                                                                                                       | 4. RACE<br>W                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-23-1898                                                                                                            |                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>DENMARK                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                       |  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL |                                                                                                                                                             |                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEA CAPTAIN |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHIPPING                                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD. |                                                                                                                              | 13b. COUNTY<br>—                                                                                                                                            |                                                 | 13c. CITY OR TOWN<br>BALTO.                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FREDERICK SCHULTZ                                                       |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIA                                                                                                      |                                                 |                                                                                 |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                        |                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>107-01-9810                                                                                     |                                                 | 17. INFORMANT<br>ADDRESS<br>Mrs. Evelyn A. Schultz - 2231 E. Fayette St.        |  |                                                                                                 |  |

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

|                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>CANCER OF THE PROSTATE GLAND                                                                                                                                                            |                                                                        |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                        |                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                          |                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 15, 19 79, to KX JUNE 16 19 79, that (I) (we) last saw the deceased alive on JUNE 16, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                            |  |
| 22b. SIGNATURE<br>Joseph Mac Mahon                                                                                                                                                                                                                                                                                            |                                                                        | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSEPH MAC MAHON                                                                                                                                                                                                                                                                     |                                                                        | 22e. ADDRESS<br>CHURCH HOSPITAL, BALTIMORE, MARYLAND                                                                       |  |

|                                                                    |                      |                                                            |                                                          |
|--------------------------------------------------------------------|----------------------|------------------------------------------------------------|----------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION          | 23b. DATE<br>6-20-79 | 23c. NAME OF CEMETERY OR CREMATORY<br>GREENMOUNT CREMATORY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harold Miller - 2331 Jefferson St. |                      | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979               | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASH. D. C.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth Frances SCHULTZ                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 01 79 |                                                                                                                                            |  | 2b. HOUR<br>10 50 PM                                                                                                       |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>Caucasian                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 08 1911                                                                                                            |                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                                  |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                 |                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital               |                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                  |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                       |                                       | 13b. COUNTY<br>Anne Arundel                                                                                                                                 |                                                 | 13c. CITY OR TOWN<br>PASADENA                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 13e. STREET ADDRESS<br>8117 Old Mill Road                                                                                                                                                                                                                                                                                                                              |                                       | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Henry LUEBEHUESA                                                                                             |                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma MEIER                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                             |                                       | 16b. SOCIAL SECURITY NO.<br>217-34-8318                                                                                                                     |                                                 | 17. INFORMANT<br>Marie George same as above                                                                                                |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular arrest</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cancer of breast &amp; metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hx of MI, ASCVD</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                       |                                                                                                                                                             |                                                 |                                                                                                                                            |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Hx of MI, ASCVD</u>                                                                                                                                                                                                           |                                       |                                                                                                                                                             |                                                 |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                         |                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>05-28</u> 19 <u>79</u> , to <u>06-1</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>06-1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.    |                                       |                                                                                                                                                             |                                                 |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>R. AREM</u>                                                                                                                                                                                                                                                                                                                                       |                                       | DEGREE                                                                                                                                                      |                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>06-1-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. AREM                                                                                                                                                                                                                                                                                                                       |                                       | 22e. ADDRESS<br>South Baltimore General Hospital                                                                                                            |                                                 |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                 |                                       | 23b. DATE<br>6/5/1979                                                                                                                                       |                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer Cem. Baltimore                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Md. 21122                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully F.H. Mountain & Tick Neck Rds. Pa.                                                                                                                                                                                                                                                                                            |                                       | ADDRESS<br>Md. 21122                                                                                                                                        |                                                 | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1979                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Priscilla Halberdy</u>                                                                    |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  | 7 9 1 4 5 9 3 |  |
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| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |  | REG. NO.                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles C. Schwensen                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-20-79                                                                                                       |  | 2b. HOUR<br>7:55 P.M.                                                                                                      |  |               |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3-08-07                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72                                                                                                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                           |  |                                                                                                                            |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lithographer                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance Co.                                                                         |  |               |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  |                                                                                                                                                             |  | 13b. COUNTY<br>-                                                                                                                                     |  | 13c. CITY OR TOWN<br>Baltimore                                                                                             |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Micharl Schwensen                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sybil Willett                                                                                       |  |                                                                                                                            |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II                                                                    |  | 17. INFORMANT<br>ADDRESS<br>A- Bertha Schwensen (wife) same as 13                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): Brain stem CVA<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 days |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>? Pancreatic CANCER                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| 19a. DATE OF OPERATION<br>None                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>abd. only                                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>None.                                                                     |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 5-24 19-79 to 6/20 19-79, that (b) (we) lost saw the deceased alive on 6/20 19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  |               |  |
| 22b. SIGNATURE<br>David C. P. Chen                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>6/20/79                                                                                                |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID CHEN                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  |                                                                                                                                                             |  | 22e. ADDRESS<br>Good Samaritan Hospital                                                                                                              |  |                                                                                                                            |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>6/25/79                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                                                                         |  |                                                                                                                            |  |               |  |
| 24. FUNERAL DIRECTOR'S NAME<br>Schmunk Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 3331 Brehms Lane<br>Balto. Md. 21213                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br>F. J. Kelly                                                                                  |  |               |  |

66341





Item Pt.2 G559 9/30/81 dad

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

79 14594

FOR  
1- STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                               |  |                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALLISON</b><br><b>*****</b>                                                                                                                                                                                                                                                                                                                                                   |  | MIDDLE<br><b>SCOTT</b>                                                                                                                   |  | LAST<br><b>SCOTT</b>                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-18-79</b>                                                                         |  | 2b. HOUR<br><b>3:35pm</b>                                        |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>Negro</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 22 38</b>                                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b>                                                                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                             |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                           |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City</b> MD                                                        |  |                                                                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                               |  | 12b KIND OF BUSINESS OR INDUSTRY                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  | 13e. STREET ADDRESS<br><b>6305 Boston Street</b>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hortense</b>                                                                         |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                          |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1958-1964</b>                                                    |  | 17 INFORMANT<br>ADDRESS<br><b>Anita Scott 6305 Boston Street</b> |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>5609</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST<br>(b) <b>ASPIRATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>INTESTINAL OBSTRUCTION (?)</b> |  |                                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                               |  |                                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAYED TO MEDICAL EXAMINER IN PART 1(a)<br><b>(1) ALCOHOLISM (2) PULMONARY TUBERCULOSIS</b><br><b>(1) ALCOHOLISM (2) PULMONARY TUBERCULOSIS</b>                                                                                                                                                                                                     |  |                                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                               |  |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                               |  |                                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                               |  |                                                                  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>6-18-79</b> to <b>6-18-79</b> , that (1) (we) lost<br>saw the deceased alive on <b>6-18-79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) did not view the body after death.                                                                                                  |  |                                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                               |  |                                                                  |  |
| 22b. SIGNATURE<br><b>A. R. Nazemi M-R</b>                                                                                                                                                                                                                                                                                                                                                                               |  | DEGREE                                                                                                                                   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                            |  |                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. NAZEMI</b>                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>100N. BROADWAY</b>                                                                                                    |  | <b>BALTIMORE MD 31</b>                                                                                                                                     |  |                                                                                                                               |  |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>6/22/79</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>                                                        |  |                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard A. Brady</b>                                                                         |  |                                                                  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.



1 2 3 4 5 6 7 8 9 10 11 12

13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14595

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                  |             |                                                                                                            | 2a. DATE KNOWN<br>OF DEATH                                  |                                                                                                                                                             |                                                                               | 2b. HOUR                                                      |                                                                                     |                                   |
| MAGGIE E. SCOTT                                                                                                                                                                                                                                                                                                                                                                                                                                      |             |                                                                                                            | MONTH DAY YEAR<br>6 13 1979                                 |                                                                                                                                                             |                                                                               | M                                                             |                                                                                     |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE     | 5. DATE OF BIRTH                                                                                           | 6. AGE (IN YEARS)                                           | IF UNDER 1 YR.                                                                                                                                              | IF UNDER 24 HRS.                                                              | 2c. DATE<br>PRONOUNCED DEAD                                   |                                                                                     |                                   |
| female                                                                                                                                                                                                                                                                                                                                                                                                                                               | black       | MONTH DAY YEAR<br>4 8 1963                                                                                 | LAST BIRTHDAY<br>63 YRS.                                    | MONTHS                                                                                                                                                      | DAYS                                                                          | MONTH DAY YEAR<br>6 13 1979                                   |                                                                                     |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                            |             | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                                     |                                   |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |             | USA                                                                                                        |                                                             |                                                                                                                                                             |                                                                               | Baltimore City                                                |                                                                                     |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                            |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                             |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                            |             | 1020N. Broadway                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                           |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13b. COUNTY | 13c. CITY OR TOWN                                                                                          |                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                               | 13e. STREET ADDRESS                                           |                                                                                     |                                   |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                  |             | Balto.                                                                                                     |                                                             |                                                                                                                                                             |                                                                               | 1020 N. Boardway                                              |                                                                                     |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                               |             |                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST               |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| James Mutts                                                                                                                                                                                                                                                                                                                                                                                                                                          |             |                                                                                                            | Rosa Anna Dickins                                           |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                |             |                                                                                                            | 16b. SOCIAL SECURITY NO.                                    |                                                                                                                                                             | 17. INFORMANT ADDRESS                                                         |                                                               |                                                                                     |                                   |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                   |             |                                                                                                            | 226-22-6864                                                 |                                                                                                                                                             | Ada Dickins 1020 N. Boardway                                                  |                                                               |                                                                                     |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                            |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                          |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix</u>                                                                                                                                                                                                                                                                                                                                                                                                   |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                       |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| (b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u>                                                                                                                                                                                                                                                                                                                                             |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                       |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                           |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                               |             |                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                                                                                                                             |                                                                               |                                                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                            |             |                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                                               |                                                                                     |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                         |             |                                                                                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                               |                                                                                     |                                   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> <u>Inquest</u> <input checked="" type="checkbox"/> and in my opinion |             |                                                                                                            |                                                             |                                                                                                                                                             |                                                                               |                                                               |                                                                                     |                                   |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u>                                                                                                                                                                                                                                                                                                                                                                                                          |             |                                                                                                            | TITLE (SPECIFY)<br>M.D. Assistant                           |                                                                                                                                                             | MEDICAL EXAMINER                                                              |                                                               |                                                                                     |                                   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                   |             |                                                                                                            | ADDRESS                                                     |                                                                                                                                                             | DATE SIGNED                                                                   |                                                               |                                                                                     |                                   |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                            |             |                                                                                                            | 111 Penn Street                                             |                                                                                                                                                             | 6/14/79                                                                       |                                                               |                                                                                     |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                         |             |                                                                                                            | 23b. DATE                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                          |                                   |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                               |             |                                                                                                            | 6/18/79                                                     |                                                                                                                                                             | Cedar Hill Cem.                                                               |                                                               | Anne Arundel Co., Md.                                                               |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                 |             |                                                                                                            |                                                             |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                 |                                                               | 25b. REGISTRAR'S SIGNATURE                                                          |                                   |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                    |             |                                                                                                            |                                                             |                                                                                                                                                             | JUN 15 1979                                                                   |                                                               | <u>Henry A. Brady</u>                                                               |                                   |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLACE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14596

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                            |                                                                                                                                                             |                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                            | FOR                                                                                                                                                         |                                                                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                            | FIRST                                                                                                                                                       | MIDDLE                                                                                          |
| VIOLA ADELLIA SCRUTON                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                            |                                                                                                                                                             |                                                                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)                                                            |
| female                                                                                                                                                                                                                                                                                                                                                                                                                                 | white                                                                                                      | Aug. 16, 1901                                                                                                                                               | 77 YRS.                                                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                               | U.S.A.                                                                                                     |                                                                                                                                                             | Baltimore City                                                                                  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              | University Hospital                                                                                        | Homemaker                                                                                                                                                   | None                                                                                            |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                                                                                | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                               | Frederick                                                                                                  | Thurmont                                                                                                                                                    |                                                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                              | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)                                                                                     |                                                                                                 |
| William McClellan Davis                                                                                                                                                                                                                                                                                                                                                                                                                | Sarah C. Yingling                                                                                          | No                                                                                                                                                          |                                                                                                 |
| 17a. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                               | 17b. INFORMANT                                                                                             | ADDRESS                                                                                                                                                     |                                                                                                 |
| 219-34-5554                                                                                                                                                                                                                                                                                                                                                                                                                            | Mr. Ralph H. Scruton, Jr.                                                                                  | Rt. #2 Box 75<br>Greencastle, Pa.                                                                                                                           |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <u>Multiple injuries</u><br>IMMEDIATE CAUSE (a) <u>8/20</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Due to, or as a consequence of</u><br>(c) <u>Due to, or as a consequence of</u>                                                                        |                                                                                                            |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                     |                                                                                                            |                                                                                                                                                             |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |                                                                                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10:37 PM 6-1-1979                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver in auto-auto collision.                                             |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road                                        | 21f. LOCATION<br>CITY OR TOWN STREET<br>Rt. 15 no. of Frederick<br>Mother Ave.                                                                              | 21g. LOCATION<br>COUNTY STATE<br>Frederick Md.                                                  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                            |                                                                                                                                                             |                                                                                                 |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       | TITLE (SPECIFY)                                                                                            | DATE SIGNED                                                                                                                                                 |                                                                                                 |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     | Assistant                                                                                                  | 6-2-79                                                                                                                                                      |                                                                                                 |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        | ADDRESS                                                                                                    |                                                                                                                                                             |                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        | 111 Penn St.                                                                                               |                                                                                                                                                             |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              | 23b. DATE                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6-4-1979                                                                                                   | Blue Ridge Cemetery                                                                                                                                         | Thurmont, Frederick, Maryland                                                                   |
| 24. FUNERAL DIRECTOR<br>(NAME AND ADDRESS)                                                                                                                                                                                                                                                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                                              | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                                                                                                 |
| Robert E. Dailey & Son<br>615 East Main Street<br>Thurmont, Md. 21788                                                                                                                                                                                                                                                                                                                                                                  | JUN 6 1979                                                                                                 |                                                                                                                                                             |                                                                                                 |

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*[Faint, mostly illegible text and markings covering the page, including some handwritten notes and possibly a signature at the bottom left.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                     |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                            | REG. NO. 9 14597                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Angelo John SCURTO                                                     |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>06 28 79                                                    |  |                                                                                                                                       | 2b. HOUR<br>9:30 P M                                       |                                              |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 11 13                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                      |  |                                                                                                                                       | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.                                          |  |                                                                                                                                       |                                                            |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto - General |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Car Assembly Line              |  |                                                                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gen Motors            |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                                                     |  | 13c. CITY OR TOWN<br>BALTO                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>726 PONTIAC AVE                                                                                                |                                                            |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Vincent Scurto                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>FRANCES FAZIO                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW II                                                                   |  | 17. INFORMANT ADDRESS<br>Mrs Wilma Scurto Same Address                                                                                                      |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory failure<br>4029<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema and hemorrhage.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension and severe arteriosclerosis  |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                     |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 22b. SIGNATURE<br>g. Fleishman                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br>08/28/79                                                                                                          |                                                            |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. Fleishman                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  | 22e. ADDRESS<br>South Balto - General                                                                                                                       |  |                                                                                                 |  |                                                                                                                                       |                                                            |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>7/2/79                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore A.A. Co Md                              |  |                                                                                                                                       |                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McBrady                                                     |  |                                                                                                                                       |                                                            |                                              |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |                                                       |                                                                                                                                                             |                                      |                                                                                                                               |                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN SEELHORST</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 25 79</b> |                                                                                                                                                             | 2b. HOUR<br><b>9<sup>22</sup> AM</b> |                                                                                                                               |                                                             |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                 |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 5 29</b>                                                                                                         |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.                                                                             |                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                                                  |                                                             |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                        |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                             |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                                                                 |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Kessler</b>                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth W. Moore</b>                                                                  |                                                       | 13e. STREET ADDRESS<br><b>301 S. Newkirk St.</b>                                                                                                            |                                      |                                                                                                                               |                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>214-26-8937</b>                                                                                              |                                                       | 17. INFORMANT ADDRESS<br><b>Herman Seelhorst, 301 S. Newkirk St.</b>                                                                                        |                                      |                                                                                                                               |                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA OF BREAST</b> <b>5 YRS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                              |  |                                                                                                                                             |                                                       |                                                                                                                                                             |                                      |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>-</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>HEPATIC FAILURE</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                             |                                                       |                                                                                                                                                             |                                      |                                                                                                                               |                                                             |
| 19a. DATE OF OPERATION<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                                                                                |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                      |                                                                                                                               |                                                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                      |                                                                                                                               |                                                             |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>6/23</b> , 19 <b>79</b> , to <b>6/25</b> , 19 <b>79</b> , that (I) <del>(my)</del> last saw the deceased alive on <b>6/25</b> , 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death. |  |                                                                                                                                             |                                                       |                                                                                                                                                             |                                      |                                                                                                                               |                                                             |
| 22b. SIGNATURE<br><b>Thomas S. Trinchetto, M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                       | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                      | 22c. DATE SIGNED<br><b>6-25-79</b>                                                                                            |                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS S. TRINCETTO, M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |                                                       | 22e. ADDRESS<br><b>BCH, 4940 EASTERN AVE., BALT. MD</b>                                                                                                     |                                      |                                                                                                                               |                                                             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>June 27 1979</b>                                                                                                            |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                                                                                                     |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                       |                                                             |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave.</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                                                                                         |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Rita K. Brady</b>                                                                            |                                                             |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 5 9 9  
REG. NO.

|                                                                                                                                                                                                                                                                                                        |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------|-----------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                           |                           | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                    |                                                              | 2a. DATE OF DEATH                                                              |                                     | 2b. HOUR                                                       |                 |
|                                                                                                                                                                                                                                                                                                        |                           | ELAINE VIRGINIA SEIDEL                                                                                 |                                                              | 6 27 79                                                                        |                                     | 12-15 AM                                                       |                 |
| 3. SEX                                                                                                                                                                                                                                                                                                 | 4. RACE                   | 5. DATE OF BIRTH                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)                              |                                                                                | 7. UNDER 1 YEAR                     |                                                                | 8. UNDER 24 HRS |
| Female                                                                                                                                                                                                                                                                                                 | Caucasian                 | 3 16 1934                                                                                              | 45 YRS                                                       |                                                                                | MONTHS DAYS                         |                                                                | HOURS MIN       |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                               | 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 13. KIND OF BUSINESS OR INDUSTRY    |                                                                |                 |
| Maryland                                                                                                                                                                                                                                                                                               | Baltimore                 | South Baltimore General Hospital                                                                       | Supervisor                                                   |                                                                                | Fort Meade H.Q.                     |                                                                |                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME  | 16. SOCIAL SECURITY NO                                                                                 | 17. INFORMANT                                                |                                                                                | 18. ADDRESS                         |                                                                |                 |
| Louis F. Seidel, Sr.                                                                                                                                                                                                                                                                                   | Alice V. Morris           | 219 32 2909                                                                                            | Louis F. Seidel, Sr.                                         |                                                                                | 8 14th Avenue, Baltimore, Md. 21225 |                                                                |                 |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                              |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| PART 1. DEATH WAS CAUSED BY                                                                                                                                                                                                                                                                            |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| IMMEDIATE CAUSE (a) Possible Cerebral Haemorrhage                                                                                                                                                                                                                                                      |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| DUE TO, OR AS A CONSEQUENCE OF (b) Blastic Crisis                                                                                                                                                                                                                                                      |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myelogenous Leukaemia                                                                                                                                                                                                                                         |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                   |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                              | 20a. AUTOPSY?                                                                  |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |
|                                                                                                                                                                                                                                                                                                        |                           |                                                                                                        |                                                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |                           | 21b. TIME OF INJURY                                                                                    |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                     |                                                                |                 |
|                                                                                                                                                                                                                                                                                                        |                           | HOUR A.M. MONTH DAY YEAR                                                                               |                                                              |                                                                                |                                     |                                                                |                 |
|                                                                                                                                                                                                                                                                                                        |                           | P.M. 19                                                                                                |                                                              |                                                                                |                                     |                                                                |                 |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                   |                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                                              | 21f. LOCATION                                                                  |                                     |                                                                |                 |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                      |                           |                                                                                                        |                                                              | STREET CITY OR TOWN COUNTY STATE                                               |                                     |                                                                |                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-25-79, to 6-27-79, that (I) (we) lost saw the deceased alive on 6-27-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                           |                                                                                                        |                                                              |                                                                                |                                     |                                                                |                 |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                         |                           |                                                                                                        |                                                              | DEGREE                                                                         |                                     | 22c. DATE SIGNED                                               |                 |
| S. Pathmanathan                                                                                                                                                                                                                                                                                        |                           |                                                                                                        |                                                              | M.D.                                                                           |                                     | 6/27/79                                                        |                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                  |                           |                                                                                                        |                                                              | 22e. ADDRESS                                                                   |                                     |                                                                |                 |
| Sivakolunthunathan Pathmanathan                                                                                                                                                                                                                                                                        |                           |                                                                                                        |                                                              | South Baltimore General Hospital<br>3001, South Hanover St.                    |                                     |                                                                |                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                              |                           | 23b. DATE                                                                                              |                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                     | 23d. LOCATION                                                  |                 |
| Burial                                                                                                                                                                                                                                                                                                 |                           | June 30, 1979                                                                                          |                                                              | Loudon Park Cemetery                                                           |                                     | Baltimore, Maryland                                            |                 |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                   |                           |                                                                                                        |                                                              | 25. DATE REC'D. BY REGISTRAR                                                   |                                     | 25b. REGISTRAR'S SIGNATURE                                     |                 |
| McMully Funeral Home of Brooklyn Balto., Md. 21225                                                                                                                                                                                                                                                     |                           |                                                                                                        |                                                              | JUN 29 1979                                                                    |                                     | [Signature]                                                    |                 |

1 2 3 4 5 6 7 8 9 10 11 12



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14600

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                             |                                                                                                                            |                                                                                                                                                             |                                                                                            |                                                                                                 |                                                                 |
|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nona E. Self.                                                        |                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06/2/79                                             |                                                                                                 | 2b. HOUR<br>Z:45 PM                                             |
| 3. SEX<br>Female                                                                                            | 4. RACE<br>WHITE                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 02 12                                                                                                              |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ALABAMA                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Weaver TEXTILE |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md |                                                                                                                            | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>BALTIMORE                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1806 Morrell Park Ave. 21230             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter HENRY                                                      |                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PEARL HITE                                                                                                 |                                                                                            |                                                                                                 |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO      |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>238-07-837                                                                                                                      |                                                                                            | 17. INFORMANT<br>NANCY SMITH<br>ADDRESS<br>1746 So. CHARES STREET<br>BALTIMORE MD. 21230        |                                                                 |

|                                                                                                                                                                                                                                                      |  |                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIAC Arrest<br>5570<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Septic Shock<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>12 hrs. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                                                      |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>s/p total colectomy, ABD Aortic aneurysm                                                                                                                                                |                                                                        |                                                                                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION<br>5/17/79                                                                                                                                                                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>gangrene of colon  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14/79, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 6/2/79, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br>George E. Lohardt                                                                                                                                                                                                                                                                                            |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>6/2/79                                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. L. INHARDT JR MD                                                                                                                                                                                                                                                                   |                                                                        | 22e. ADDRESS<br>UNIV Hospital                                                                                                                        |                                                                                                                               |

|                                                                                     |                     |                                                             |                                                            |
|-------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------|------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                              | 23b. DATE<br>6-6-79 | 23c. NAME OF CEMETERY OR CREMATORY<br>ZOAR BAPTIST CH. Com. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SHELBY, N.C. |
| 24. FUNERAL DIRECTOR<br>NAME<br>MCCULLY FUNERAL HOME IF So. BALTO. BALTO. MD. 21230 |                     | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1979                 | 25b. REGISTRAR'S SIGNATURE<br>P. J. Kelly                  |

U U C . . 5

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14601

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                    |                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Beulah H. L. Sessions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/23/79                                     |                                                                                    | 2b. HOUR<br>8:00A                                                                               |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 2, 1898                                                                                                         |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 years YRS.                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Alabama                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                         |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Villa Nursing Home |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>School Teacher |                                                                                    | 12b. KIND OF BUSINESS<br>Montgomery                                                             |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                           |                                                                                                                                                             | 13b. COUNTY<br>Howard                                                              | 13c. CITY OR TOWN<br>Ellicott City                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Kirk Long                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Love                        |                                                                                    |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>417-50-4451A                                                                                                                    |                                                                                    | 17. INFORMANT<br>ADDRESS<br>Road 21043<br>Mr. William B. Sessions, 2550 North Farm |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line. Do not list more than 10 causes.)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure</u><br>4039<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic kidney disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                    |                                                                                                 |

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY?  
YES ☐ NO ☒

19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21a. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21b. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21c. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22. I certify that (I) (this hospital) attended the deceased from June 5, 1979 to 23 June 1979 that (I) (we) last saw the deceased alive on 23 June 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23a. SIGNATURE  
William J. Bryson M.D.

23b. PHYSICIAN'S NAME (TYPE OR PRINT)  
Dr. Bryson, M.D.

23c. ADDRESS  
5772 Westview Mall

23d. DATE SIGNED  
25 June 79

|                                                                               |                      |                                                            |                                                                  |
|-------------------------------------------------------------------------------|----------------------|------------------------------------------------------------|------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                           | 23b. DATE<br>6/27/79 | 23c. NAME OF CEMETERY OR CREMATORY<br>Montgomery Mem. Cem. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Montgomery Alabama |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave. |                      | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979               | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Bryson</u>            |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with various fields and lines of text.]

[Large block of extremely faint, illegible text, likely the body of a memorandum or report, spanning the bottom half of the page.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 14602

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Russell E. Shaeffer</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 18 79</b>                                |                                                                                      | 2b. HOUR<br><b>10<sup>00</sup> a.m.</b>                                                                                               |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>W</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 23, 1901</b>                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |                                                                                      |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O RR.</b>                              |                                                                                                                                       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Shaeffer</b>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Mielke</b>                  |                                                                                      |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>705-03-9122 RR</b>                                                                                                           | 17. INFORMANT<br><b>Palma M. Shaeffer</b> Same                                       |                                                                                      |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>extensive acute anterior MI.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Adult onset diabetes mellitus, old anteroposterior M.I.</b>                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                    |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/17</b> 19 <b>79</b> , to <b>6/18</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                                       |
| 22b. SIGNATURE<br><b>Joseph D'Antonio, M.D.</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                             | DEGREE<br><b>M.D.</b>                                                                |                                                                                      | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH D'ANTONIO</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                             | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                       |                                                                                      |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>6-21-79</b>                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>                                                                                                       |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b>         |                                                                                                                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins Sons Co.</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                  |                                                                                      |                                                                                                                                       |
| 4905 York Rd. Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                 |                                                                                      |                                                                                                                                       |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 6 0 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                   |                                                                                                                                                            |                                                             |                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH SHALAT</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 25, 1979</b> |                                                                                                 | 2b. HOUR<br><b>10:50A<sub>M</sub></b>                                                                                      |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><b>WHITE</b>                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 10 1896</b>                                                                                                   |                                                             | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ROUMANIA</b>                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                          |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5952 GREEN MEADOW PKWY APT. B</b> |                                                                                                                                                            |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMPLOYED</b>        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BARBER</b>                                                                         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                         |                                                                                                                                                   | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                            | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5952 GREEN MEADOW PKWY (21209)</b>                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SASCHA NATHAN SHALAT</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARNA [unclear] [unclear]</b>                                                                         |                                                             |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br><b>119-18-6840A</b>                                                                                                            |                                                             | 17 INFORMANT<br><b>REBECCA PERALES</b> ADDRESS<br><b>5952 GREEN MEADOW PKWY (21209)</b>         |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CA OF PROSTATE C METASTASES</b><br><b>185-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                                   |                                                                                                                                                            |                                                             |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 MONTHS</b>                                                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                            |                                                             |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |                                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                          |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> 19 <b>79</b> , to <b>JUNE</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5/15</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                           |                                                                                                                                                   |                                                                                                                                                            |                                                             |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | DEGREE<br><b>MD</b>                                                                                                                                        |                                                             | 22c. DATE SIGNED<br><b>6/25/79</b>                                                              |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BORIS KERZNER</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                   | 22e. ADDRESS<br><b>2435 W. BEVERDE AVE BALTO, MD 21215</b>                                                                                                 |                                                             |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                       | 23b. DATE<br><b>6/26/79</b>                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>                                                                                                  |                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                   | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. 21215</b>                                                                                               |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>                                             |                                                                                                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2777.

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~~Chambers~~

Case 14001-1

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Page 14

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                               |  | 7 9 1 4 6 0 4                                                                                                                           |  | REG. NO.                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CORBETT LEE SHAVER</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>06 10 79 0638<sup>AM</sup></b>                                                                             |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br><b>CAUCASIAN</b>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 19 1919</b>                                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN                                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA. U.S.A.</b>                                                                                                                                                                                                                                                                                                                                           |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                           |  |                                                                                                                                       |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>U.S.P.H.S. HOSPITAL</b> |  |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. ARMY (RET'D)</b>                                                |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                                      |  |
| 13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  | 13b COUNTY                                                                                                                                                 |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>HEZZIE SHAVER</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY HILTON</b>                                                                                            |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                          |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII, KOREA 232/24/2887</b>                                                |  | 17 INFORMANT ADDRESS<br><b>Mrs. Corbett L. Shaver 1544 Elrino St</b>                                                                                       |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Liver insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Micro nodular cirrhosis</b> |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>terminal</b><br><b>months</b><br><b>unknown</b>                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                            |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                    |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 22a I certify that (this hospital) attended the deceased from <b>5/1/79</b> 19 <b>79</b> to <b>6/10</b> 19 <b>79</b> that (I <del>was</del> ) last saw the deceased alive on <b>6/10</b> 19 <b>79</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I <del>was</del> ) (did) (did not) view the body after death.                         |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 22b SIGNATURE<br><b>Duncan Salmon</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  | DEGREE<br><b>M.D.</b>                                                                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>06/10/79</b>                                                                                                    |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DUNCAN SALMON</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  | 22e ADDRESS<br><b>3100 WYMAN PARK DR BALT MD 21211</b>                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                  |  | 23b DATE<br><b>6/13/79</b>                                                                                                              |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St Stanislaus</b>                                                                                                  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                                                                           |  |                                                                                                                                       |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  | ADDRESS<br><b>1005 Dundalk Avenue</b>                                                                                                                      |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                                                                         |  | 25b REGISTRAR'S SIGNATURE<br><i>Anthony McBrady</i>                                                                                   |  |

14304 78

St Stanislaus

8/13/79

Initial

Baltimore

1005 Dundalk Avenue

Walter Dobrowski

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14605

1- STATE REGISTRAR

|                                                                                            |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                               |  |                  |  |                                                         |  |               |  |               |  |
|--------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|------------------|--|---------------------------------------------------------|--|---------------|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                        |  | FIRST<br>ALBERTA                                                                                                               |  | MIDDLE<br>M.                                                                                                                                                |  | LAST<br>SHEARS                                                                                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED                          |  | MONTH<br>6       |  | DAY<br>26                                               |  | YEAR<br>1979  |  | 2b. HOUR<br>M |  |
| 3. SEX<br>female                                                                           |  | 4. RACE<br>negro                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 27 16                                                                                                               |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>63 YRS.                                                   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                      |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 26 1979 |  | 7d. HOUR<br>a |  | 7e. MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |                                                               |  |                  |  |                                                         |  |               |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>504 E. Eager St. |  |                                                                                                                                                             |  |                                                                                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |               |  |               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                               |  |                  |  |                                                         |  |               |  |               |  |
| 13a. STATE<br>Md.                                                                          |  | 13b. COUNTY                                                                                                                    |  | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>933 N. Wolfe St.                       |  |                  |  |                                                         |  |               |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Thompson                                    |  |                                                                                                                                |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nora Fitzhugh                                  |  |                                                               |  |                  |  |                                                         |  |               |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                |  |                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-14-7432                                                                                      |  |                                                                                                 |  | 17. INFORMANT ADDRESS<br>Elizabeth Shears 2431 Barclay St.    |  |                  |  |                                                         |  |               |  |               |  |

|                                                                                                                                                                                                                                                                                                                   |  |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

|                                                                                                                        |  |                                                             |  |                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

|                                                          |  |                              |  |                        |  |
|----------------------------------------------------------|--|------------------------------|--|------------------------|--|
| ACTUAL SIGNATURE<br>                                     |  | TITLE (SPECIFY)<br>Assistant |  | DATE SIGNED<br>6-26-79 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D. |  | ADDRESS<br>111 Penn St.      |  |                        |  |

|                                                        |  |                      |  |                                                      |  |                                                              |  |
|--------------------------------------------------------|--|----------------------|--|------------------------------------------------------|--|--------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>6/30/79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H         |  |                      |  | ADDRESS<br>1101 E. North Ave.                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                 |  |
|                                                        |  |                      |  |                                                      |  | 25b. REGISTRAR'S SIGNATURE<br>                               |  |

100-101



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7914606

|                                                                                   |                                                                                                                                  |                                                                                                                                                             |                                                                  |                                                           |                                   |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NATALIE D. SHEPPERSON |                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 26, 1979             |                                                           | 2b. HOUR<br>4:35A <sub>M</sub>    |
| 3. SEX<br>Female                                                                  | 4. RACE<br>Black                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 24 09                                                                                                               |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70<br>YRS.             |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |                                   |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home & Hosp. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                           | 12b. KIND OF BUSINESS OR INDUSTRY |

|                                                                                                              |  |                                                                        |                                                              |                                                                  |                                                                                                 |                                          |
|--------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |  |                                                                        | 13b. COUNTY                                                  | 13c. CITY OR TOWN<br>Balto.                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1903 N. Wolfe St. |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry H. Doswell                                                   |  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elnora West |                                                                  |                                                                                                 |                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>086-09-1160 |                                                              | 17. INFORMANT<br>ADDRESS<br>John E. Shepperson 1903 N. Wolfe St. |                                                                                                 |                                          |

|                                                                                                                                                                                 |  |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>1749<br>CANCER OF THE BREAST WITH METASTASIS |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                 |  |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                           |  |                                                 |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                                         |  |                                                                               |  |                                                                                      |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 22, 1979, to JUNE 26, 1979, that (I) (we) lost saw the deceased alive on JUNE 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (two) (did not) view the body after death. |  |                                                                               |  |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>Joseph Mac Mahon                                                                                                                                                                                                                                                                                      |  | DEGREE<br>M.B.B.Ch.                                                           |  | 22c. DATE SIGNED<br>6-26-79                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSEPH MACMAHON, M.D.                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD |  |                                                                                      |                                                                                                                            |

|                                                     |                     |                                                        |                                                             |
|-----------------------------------------------------|---------------------|--------------------------------------------------------|-------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial | 23b. DATE<br>7/1/79 | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Bapt. Ch. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Meherrin, Va. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H      |                     | ADDRESS<br>1101 E. North Ave.                          |                                                             |
| 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979        |                     | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCready         |                                                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

Female

Black

8 24 03

70

US-      Wt.      1903 N. Wolfe St.

Black      1903 N. Wolfe St.

No.

Black

1903 N. Wolfe St.

Male

M.

Doyle

Black

Black

No.

033-09-1100 John E. Thompson 1903 N. Wolfe St.

1903 N. Wolfe St.

Wt.

1903 N. Wolfe St.

1903 N. Wolfe St.

1903 N. Wolfe St.

1903 N. Wolfe St.

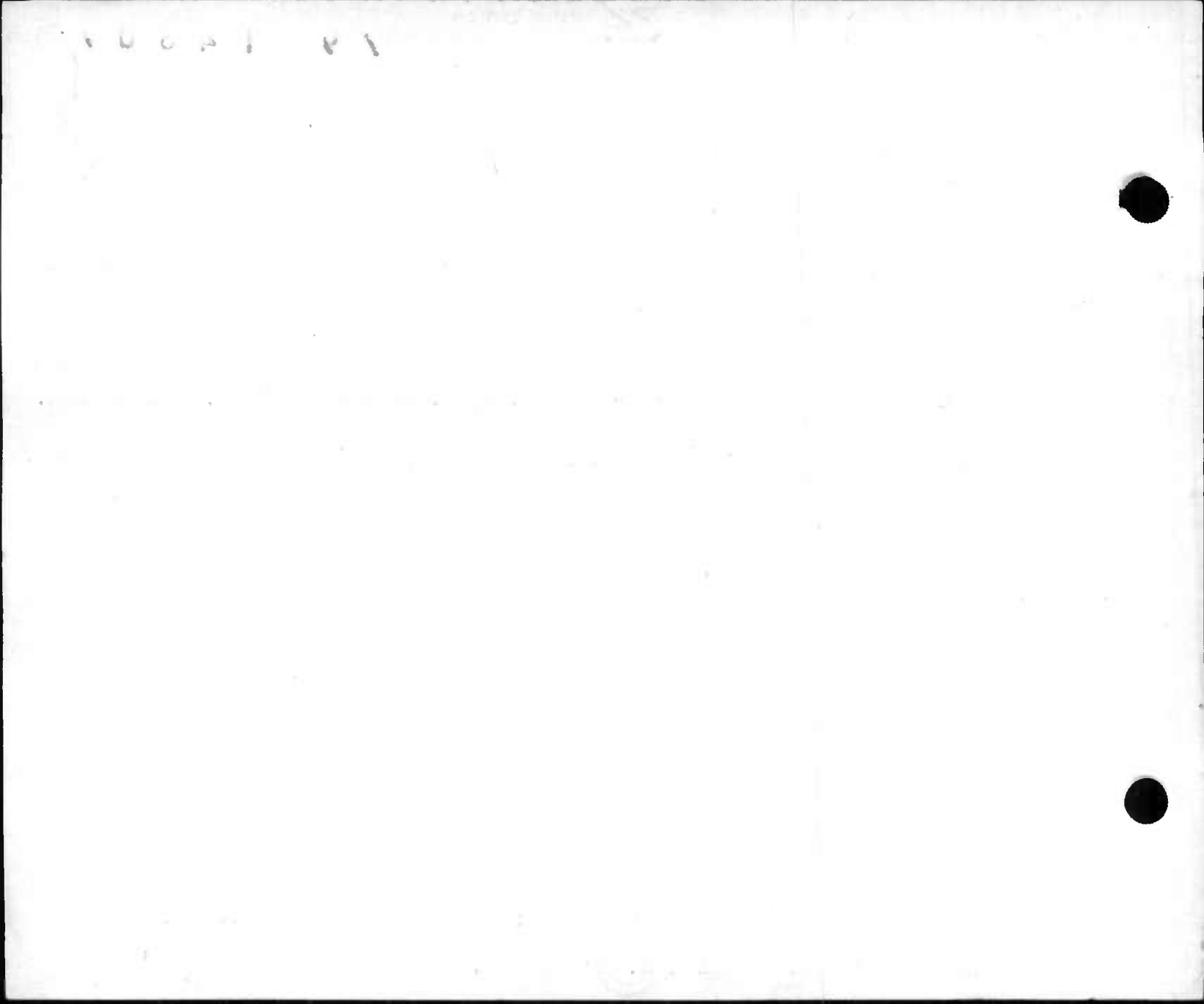


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14607

REG. NO.

|                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                            |  |                                                                     |  |                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                      |  | 2a. DATE OF DEATH                                                                                      |  | MONTH                                                                                                                                        |  | DAY                                                                                                                                        |  | YEAR                                                                |  | 2b. HOUR            |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                             |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                       |  | LAST                                                                                                                                       |  | 6                                                                   |  | 1479 170 M          |  |
| ERNEST                                                                                                                                                                                      |  | JHORT                                                                                                  |  |                                                                                                                                              |  |                                                                                                                                            |  |                                                                     |  |                     |  |
| 3 SEX                                                                                                                                                                                       |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH                                                                                                                              |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                             |  | 7a. IF UNDER 1 YEAR                                                 |  | 7b. IF UNDER 24 HRS |  |
| M                                                                                                                                                                                           |  | B                                                                                                      |  | 6/21/13                                                                                                                                      |  | 65 YRS                                                                                                                                     |  | MONTHS                                                              |  | DAYS                |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                   |  | 7d. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                        |  |                                                                     |  |                     |  |
| Md                                                                                                                                                                                          |  | USA                                                                                                    |  |                                                                                                                                              |  | Bald. City                                                                                                                                 |  |                                                                     |  | MD                  |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |                                                                     |  |                     |  |
| Baltimore                                                                                                                                                                                   |  | Lutheran Hospital 730 Ash                                                                              |  |                                                                                                                                              |  |                                                                                                                                            |  |                                                                     |  |                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                |  | 13b. STATE                                                                                             |  | 13c. COUNTY                                                                                                                                  |  | 13d. CITY OR TOWN                                                                                                                          |  | 13e. INSIDE CITY LIMITS?                                            |  | 13f. STREET ADDRESS |  |
| Md                                                                                                                                                                                          |  | Balt.                                                                                                  |  |                                                                                                                                              |  |                                                                                                                                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1336 FULTON ST.     |  |
| 14 FATHER'S NAME                                                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME                                                                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                            |  | 16b. SOCIAL SECURITY NO                                                                                                                    |  | 17 INFORMANT                                                        |  | ADDRESS             |  |
| Unkn                                                                                                                                                                                        |  | Unkn                                                                                                   |  | No                                                                                                                                           |  | 219-18-6775                                                                                                                                |  | Lucy R. Short                                                       |  | 1336 N. Fulton Ave. |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                    |  | PART 1 DEATH WAS CAUSED BY                                                                             |  | IMMEDIATE CAUSE (a)                                                                                                                          |  | 2765                                                                                                                                       |  | RESPIRATORY                                                         |  | Arrssi              |  |
|                                                                                                                                                                                             |  |                                                                                                        |  | (b)                                                                                                                                          |  | Hemoptysis                                                                                                                                 |  |                                                                     |  |                     |  |
|                                                                                                                                                                                             |  |                                                                                                        |  | (c)                                                                                                                                          |  |                                                                                                                                            |  |                                                                     |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                           |  | Hypovolemia                                                                                            |  |                                                                                                                                              |  |                                                                                                                                            |  |                                                                     |  |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                             |  |                                                                     |  |                     |  |
|                                                                                                                                                                                             |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |                                                                     |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                          |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                               |  |                                                                                                                                            |  |                                                                     |  |                     |  |
|                                                                                                                                                                                             |  | 1400 PM 6/17/79                                                                                        |  |                                                                                                                                              |  |                                                                                                                                            |  |                                                                     |  |                     |  |
| 21d. INJURY OCCURRED                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                |  | CITY OR TOWN                                                                                                                               |  | COUNTY                                                              |  | STATE               |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                           |  |                                                                                                        |  | dtd 1                                                                                                                                        |  | 1979                                                                                                                                       |  | 6/17                                                                |  | 1979                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from                                                                                                                          |  | 22b. SIGNATURE                                                                                         |  | DEGREE                                                                                                                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                    |  |                     |  |
| saw the deceased alive on 6/17/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | RAVENDHARAN N                                                                                          |  |                                                                                                                                              |  |                                                                                                                                            |  | 6/17/79                                                             |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                       |  | 22e. ADDRESS                                                                                           |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                    |  | 23b. DATE                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION       |  |
|                                                                                                                                                                                             |  | Lutheran Hosp of Md.                                                                                   |  | Burial                                                                                                                                       |  | 6/22/79                                                                                                                                    |  | King Mem. Park                                                      |  | Balto. Co., Md.     |  |
| 24 FUNERAL DIRECTOR                                                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                   |  |                                                                                                                                            |  |                                                                     |  |                     |  |
| Wm C March F/H                                                                                                                                                                              |  | 1101 E. North Ave.                                                                                     |  | JUN 19 1979                                                                                                                                  |  | R. H. H. H. H.                                                                                                                             |  |                                                                     |  |                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14608

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------|-----------------|---------------------------------------------------------------------|-----------------|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE | LAST                                                                   | 2a. DATE OF DEATH                    |                                                                                | MONTH           | DAY                                                                 | YEAR            | 2b. HOUR                                                       |  |
| Mildred                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |        | Simpson                                                                | 6                                    |                                                                                | 1               | 79                                                                  |                 | 5:15 P.M.                                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |        |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                                                                | IF UNDER 1 YEAR |                                                                     | IF UNDER 24 HRS |                                                                |  |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                                           | B.                                                                                                        | MONTH DAY YEAR<br>4 2 22                                                                                                                                    |        |                                                                        | 57 YRS.                              |                                                                                | MONTHS DAYS     |                                                                     | HOURS MIN.      |                                                                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                                |                 |                                                                     |                 |                                                                |  |
| A/A.                                                                                                                                                                                                                                                                                                                                                                                                                                                        | U.S.A.                                                                                                    |                                                                                                                                                             |        |                                                                        | Baltimore City MD.                   |                                                                                |                 |                                                                     |                 |                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                 |                                                                     |                 |                                                                |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Edgewood Nursing Home                                                                                     |                                                                                                                                                             |        | Housewife                                                              |                                      | Home.                                                                          |                 |                                                                     |                 |                                                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 13b. COUNTY                                                                                                                                                 |        | 13c. CITY OR TOWN                                                      |                                      | 13d. INSIDE CITY LIMITS?                                                       |                 | 13e. STREET ADDRESS                                                 |                 |                                                                |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |        | Baltimore                                                              |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                 | 2614 Oswego                                                         |                 |                                                                |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |        | 15. MOTHER'S MAIDEN NAME                                               |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| FIRST MIDDLE LAST<br>MAJOR Terry                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |        | FIRST MIDDLE LAST<br>Gussie Gardman                                    |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |        | 16b. SOCIAL SECURITY NO.                                               |                                      | 17. INFORMANT ADDRESS                                                          |                 |                                                                     |                 |                                                                |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      | NORMAN Simpson 2614 Oswego                                                     |                 |                                                                     |                 |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident (CVA)</u><br><u>3352</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Cardiac failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pseudo-Bulbar Pulsus</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Gastroenteritis</u><br>(c) <u></u> |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 |                                                                     |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                      |                                                                                |                 | 20a. AUTOPSY?                                                       |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                 |                                                                     |                 |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                 |                                                                     |                 |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 2 1979</u> to <u>June 3 1979</u> , that (I) (we) last saw the deceased alive on <u>June 2 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                    |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |        | DEGREE                                                                 |                                      |                                                                                |                 | 22c. DATE SIGNED                                                    |                 |                                                                |  |
| Mannel Sodaro MD                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      |                                                                                |                 | 6/2/79                                                              |                 |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |        | 22e. ADDRESS                                                           |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| DR. SODARO                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |        | 4624 York Rd. Balt Md 21212                                            |                                      |                                                                                |                 |                                                                     |                 |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |        | 23b. DATE                                                              |                                      | 23c. NAME OF CEMETERY OR CREMATORY                                             |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                 |                                                                |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |        | 6/6/79                                                                 |                                      | Arbutus                                                                        |                 | Baltimore Baltimore Md.                                             |                 |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      | 25a. DATE REC'D. BY REGISTRAR                                                  |                 | 25b. REGISTRAR'S SIGNATURE                                          |                 |                                                                |  |
| JAMES A. MORTON & SONS - 1701 LAURENS                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |        |                                                                        |                                      | JUN 6 1979                                                                     |                 | Pitney Keedy                                                        |                 |                                                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |                                                                                                                                     |                                                                                                                                                             |                                                                                    |                                                                                              |                                              |                                                                                                                                 |  |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>LAST</i> <i>Singletary</i> <i>FIRST</i> <i>Decatur</i>                                                                                                                                                                                                                                                                                     |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH <i>6</i> DAY <i>26</i> YEAR <i>19</i>                                                                                            |                                                                                    | 2b. HOUR <i>8:45 AM</i>                                                                      |                                              | REG. NO. <i>14609</i>                                                                                                           |  |                                              |  |
| 3. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE <i>NEGRO</i>                                                                                                                | 5. DATE OF BIRTH<br>MONTH <i>10</i> DAY <i>13</i> YEAR <i>41</i>                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY) <i>37</i>                                          | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>                                               |                                              | IF UNDER 24 HRS<br>HOURS <i></i> MIN. <i></i>                                                                                   |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NC</i>                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                  |                                                                                              |                                              |                                                                                                                                 |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balt. M.D.</i>                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hosp.</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>LABORER</i> |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY <i></i>    |                                                                                                                                 |  |                                              |  |
| 13a. STATE <i>MD</i>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                     | 13b. COUNTY <i>Baltimore</i>                                                                                                                                | 13c. CITY OR TOWN <i>Baltimore</i>                                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>2418 Lakeview Ave</i> |                                                                                                                                 |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST <i>Lawrence</i> MIDDLE <i>Singletary</i>                                                                                                                                                                                                                                                                                                               |                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Frances</i> MIDDLE <i></i> LAST <i></i>                                                                                |                                                                                    |                                                                                              |                                              |                                                                                                                                 |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>                                                                                                                                                                                                                                                                                                       |                                                                                                                                     | 16b. SOCIAL SECURITY NO. <i>24670-7046</i>                                                                                                                  |                                                                                    | 17. INFORMANT ADDRESS<br><i>House 2418 Lakeview Ave</i>                                      |                                              |                                                                                                                                 |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Lung Cancer</i><br><i>5130</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>Smoking</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |                                                                                                                                     |                                                                                                                                                             |                                                                                    |                                                                                              |                                              |                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                                                                                             |                                                                                    |                                                                                              |                                              |                                                                                                                                 |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M.</i> <i>19</i>                                                                                    |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                              |                                                                                                                                 |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                         |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                            |                                              |                                                                                                                                 |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                     |                                                                                                                                     |                                                                                                                                                             |                                                                                    |                                                                                              |                                              |                                                                                                                                 |  |                                              |  |
| 22b. SIGNATURE<br><i>Francis B. Ruff, M.D.</i>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     |                                                                                                                                                             |                                                                                    | DEGREE<br><i></i>                                                                            |                                              | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>6-26-79</i>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     |                                                                                                                                                             |                                                                                    | 22e. ADDRESS                                                                                 |                                              |                                                                                                                                 |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPRINT) <i>Removal</i>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                     | 23b. DATE <i>6/25/79</i>                                                                                                                                    |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY <i>Kenilworth Plaz</i>                                    |                                              | 23d. LOCATION<br>CITY OR TOWN <i>Whiteville</i> COUNTY <i>NC</i> STATE <i></i>                                                  |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Thomas R. Hays</i> ADDRESS <i>6509 1/2 W ST</i>                                                                                                                                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                             |                                                                                    | 25. DATE REG'D. BY REGISTRAR <i>JUN 27 1979</i>                                              |                                              | 25b. REGISTRAR'S SIGNATURE <i>Patricia Hays</i>                                                                                 |  |                                              |  |

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RECEIVED  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

(M)

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

*[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or date.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                              |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  | REG. NO. 14610                                                                                                                     |  |          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  | 2a. DATE KNOWN OF DEATH                                                                                                            |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick A. Sipes                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  | XX MONTH DAY YEAR 6 24 19 79                                                                                                       |  | M 6:15P  |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE White                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR Apr 23, 1953                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.                                                      |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 24 19 79                                                             |  | M                                                                                                                                  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                     |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 10. CITY OR TOWN OF DEATH Baltimore City                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machanic                       |  | 12b. KIND OF BUSINESS OR INDUSTRY - -                                                                          |  |                                                                                                                                    |  |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY - -                                                                                                                   |  | 13c. CITY OR TOWN Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 3511 Greenspring Ave. 21211                                                                |  |                                                                                                                                    |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Sipes, Sr.                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellsie Wink                                       |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO. - -                                                                                                      |  | 17. INFORMANT Mrs. Ellsie Sipes-3511 Greenspring Ave.                                                                                                    |  | ADDRESS                                                                                      |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries with complications<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                  |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |                                                                                              |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |                                                                                                                                    |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 XX 5 9 1979                                                                                               |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in motorcycle/auto impact |  |                                                                                                                                    |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                            |  |                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street                                                                                       |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Druid Hill Ave & McMechen St. Balto. City, MD                   |  |                                                                                                                                    |  |          |  |
| 22a. I certify that I have charge of the remains described above. Held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                   |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |          |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | TITLE (SPECIFY) M.D. Deputy Chief                                                                                                                        |  |                                                                                              |  | DATE SIGNED 6/25/79                                                                                            |  |                                                                                                                                    |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | ADDRESS 111 Penn St. Balto., MD.                                                                                                                         |  |                                                                                              |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                     |  | 23b. DATE 6/28/79                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland                                  |  |                                                                                                                |  |                                                                                                                                    |  |          |  |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home 3818 Roland Ave.                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR JUN 28 1979                                                    |  | 25b. REGISTRAR'S SIGNATURE                                                                                     |  |                                                                                                                                    |  |          |  |









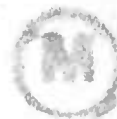
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 6 1 1

|                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|-----------------|--|-------|--|------|--|----------|--|---------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                    |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                      |  | LAST                                                                                                                                       |  | 2a. DATE OF DEATH   |  | MONTH           |  | DAY   |  | YEAR |  | 2b. HOUR |  | 9 A. M. |  |
| Elsie                                                                                                                                                                                                  |  | A.                                                                                                     |  | Sippel                                                                                                                                                      |  |                                                                                                                                            |  | 6-11-79             |  |                 |  |       |  |      |  |          |  |         |  |
| 3. SEX                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                                                                                          |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |  |       |  |      |  |          |  |         |  |
| Female                                                                                                                                                                                                 |  | White                                                                                                  |  | 10-19-93                                                                                                                                                    |  | 85                                                                                                                                         |  | MONTHS              |  | DAYS            |  | HOURS |  | MIN. |  |          |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| Md.                                                                                                                                                                                                    |  | U.S.A.                                                                                                 |  |                                                                                                                                                             |  | Balto. City                                                                                                                                |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| Balto.                                                                                                                                                                                                 |  | 3565 Elmley Ave.                                                                                       |  | Housewife                                                                                                                                                   |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                           |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                                                                                                   |  | 13e. STREET ADDRESS |  |                 |  |       |  |      |  |          |  |         |  |
| Md.                                                                                                                                                                                                    |  |                                                                                                        |  | Balto                                                                                                                                                       |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 3565 Elmley Ave.    |  |                 |  |       |  |      |  |          |  |         |  |
| 14. FATHER'S NAME                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| Ferdinand                                                                                                                                                                                              |  | Staff                                                                                                  |  | Emma                                                                                                                                                        |  | Unknown                                                                                                                                    |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                                                                                                    |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| No                                                                                                                                                                                                     |  | 215-28-9803                                                                                            |  | Emanuel Sippel, Sr.,                                                                                                                                        |  | 3565 Elmley Ave.                                                                                                                           |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u>                                             |  | (b) <u>Myelomonocytic Leukemia</u>                                                                     |  | (c) <u>Arteriosclerotic CVD disease &amp; Congestive heart failure</u>                                                                                      |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 2059                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic CVD disease &amp; Congestive heart failure</u> |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                             |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 3/17/79                                                                                                                                                                                                |  | Subcapital fracture, rt Hip.                                                                           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                     |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
|                                                                                                                                                                                                        |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
|                                                                                                                                                                                                        |  | P.M. 19                                                                                                |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                               |  | CITY OR TOWN                                                                                                                               |  | COUNTY              |  | STATE           |  |       |  |      |  |          |  |         |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                      |  |                                                                                                        |  | Street                                                                                                                                                      |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
|                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> 19 <u>79</u> to <u>6/11</u> 19 <u>79</u> that (I) (we) lost                                                              |  | 22b. SIGNATURE                                                                                         |  | DEGREE                                                                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED    |  |                 |  |       |  |      |  |          |  |         |  |
| saw the deceased alive on <u>6/5</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                                                        |  | L.B. Stevens, M.D.                                                                                     |  | M.D.                                                                                                                                                        |  |                                                                                                                                            |  | 6/12/79             |  |                 |  |       |  |      |  |          |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                  |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
|                                                                                                                                                                                                        |  | 3400 Erdman Ave.                                                                                       |  |                                                                                                                                                             |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                              |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                                                                                              |  | COUNTY              |  | STATE           |  |       |  |      |  |          |  |         |  |
| Burial                                                                                                                                                                                                 |  | 6-14-79                                                                                                |  | Loudon Park                                                                                                                                                 |  | Balto.,                                                                                                                                    |  |                     |  | Md.             |  |       |  |      |  |          |  |         |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |                                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |
| NAME                                                                                                                                                                                                   |  | ADDRESS                                                                                                |  | JUN 13 1979                                                                                                                                                 |  | Fitzroy McCurdy                                                                                                                            |  |                     |  |                 |  |       |  |      |  |          |  |         |  |

11041 VV



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

79 14612

|                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                           |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BERTIE SKAGGS</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 4, 1979</b>                |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>9 AM</b>                                                                                                                    |                                                                                                 |                                                                                                                            |                                                          |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 3 1884</b>                                                                                                       |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b>                                                                                               |                                                                                                 | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                                                                               |                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD                                                                                     |                                                                                                 |                                                                                                                            |                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MASON F. LORR N.H.</b> |                                                                           |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beautician</b>                                                      |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                          |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        | 13b. COUNTY<br><b>Baltimore</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Dundalk</b>                                            |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            |                                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Edward Sarver</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cornelia Reynolds</b> |                                                                                                                                                             |                                                                                | 16. STREET ADDRESS<br><b>8 Vista Mobile Drive</b>                                                                                          |                                                                                                 |                                                                                                                            |                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>274-05-0541</b>                            |                                                                                                                                                             | 17. INFORMANT<br><b>B.J. Sarver</b>                                            |                                                                                                                                            | ADDRESS<br><b>8 Vista Mobile Drive</b><br><b>Baltimore, MD 21222</b>                            |                                                                                                                            |                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest.</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Coronary Artery Disease</b><br>(c) <b>years</b>  |  |                                                                                                                                        |                                                                           |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                           |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                   |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>              |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 1976</b> to <b>4 Jun 79</b> , that I (we) lost saw the deceased alive on <b>4 Jun 79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                        |                                                                           |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                          |
| 22b. SIGNATURE<br><b>Edmunds Beadman MD</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        | DEGREE<br><b>MD</b>                                                       |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>4 Jun 79</b>                                                                                        |                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 22e. ADDRESS                                                              |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        | 23b. DATE<br><b>6/5/79</b>                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                 |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Baltimore, MD</b>                   |                                                                                                                            |                                                          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Avenue, Dundalk, MD 21222</b>                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                                           |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1979</b>                             |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                                           |                                                                                                                            |                                                          |

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ВАСИЛИЙ ИВАНОВИЧ

Section of History Department  
Columbia University

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 6 1 3

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                    |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lawrence F. SMART</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 21, 1979</b>                                     |                                                                                     | 2b HOUR<br><b>4:30 P.M.</b>                                                                                                |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                               | 4 RACE<br><b>White</b>                                                                                                             | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 4, 1924</b>                                                                                                    |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                        | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Landscaping</b>          |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Nursery</b>                                                                         |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                             | 13b COUNTY<br><b>Balto.-Owings Mills</b>                                                                                           | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS<br><b>10909 Baronet Road</b>                                     |                                                                                                                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Smart</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                    | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Reeside</b>                                                                                       |                                                                                                |                                                                                     |                                                                                                                            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                    | 16b SOCIAL SECURITY NO.<br><b>220-14-2652</b>                                                                                                              |                                                                                                | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Virginia B. Smart Same</b>                       |                                                                                                                            |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCUA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                    |                                                                                                                                                            |                                                                                                |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                    | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER).                                                                                                                                                                                                          |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/3 4/4 1979</b>                                                                                     |                                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/3 4/4 1979</b> to <b>6/21 1979</b> , that (I) (we) last saw the deceased alive on <b>6/21 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death)                                  |                                                                                                                                    |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                            |
| 22b SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    | DEGREE                                                                                                                                                     |                                                                                                | 22c. DATE SIGNED<br><b>6/27/79</b>                                                  |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Stuart E. Ross, M.D.</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                    | 22e ADDRESS<br><b>10219 Dolfield Rd. Owings Mills, Md.</b>                                                                                                 |                                                                                                |                                                                                     |                                                                                                                            |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                          | 23b. DATE<br><b>6-23-79</b>                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                                                                                                   |                                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>                |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                                                                                        |                                                                                                | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |                                                                                                                            |
| 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14614

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                               |                                                                                                                                |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna C Smith                                                                                                                                                                                                                                      |                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 6 79                              |                                                                                      | 2b. HOUR<br>6:45 AM                                                                             |  |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                   | 4. RACE<br>W                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 15 30                                                                                                               |                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.                                           |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Md. HSP. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Packer |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>F&G Co.                                                    |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                             |                                                                                                                                |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                   | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Konstanty S. style                                                                                                                                                                                                                                                  |                                                                                                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Stankiewicz Mary          |                                                                                      |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                        |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>178 122 799                                                                                                                     |                                                                            | 17. INFORMANT<br>ADDRESS<br>178 22 7919 charz - Univ. of Md. HSP.                    |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Massive stroke<br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Post coronary artery by pass graft<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) few coronary artery disease       |                                                                                                                                |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                                 |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                           |                                                                                                                                |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                                 |  |
| 19a. DATE OF OPERATION<br>5.31.79                                                                                                                                                                                                                                                                             |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>coronary artery disease                                                                                 |                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                    |                                                                                                                                |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                      |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5:31 19 79, to 6:6 19 79, that (I) (we) last saw the deceased alive on 6:6 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                                 |  |
| 22b. SIGNATURE<br>Abdulla A. Attum MD<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                 |                                                                                                                                |                                                                                                                                                             |                                                                            |                                                                                      | 22c. DATE SIGNED                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Abdulla A. ATTUM MD                                                                                                                                                                                                                                                  |                                                                                                                                |                                                                                                                                                             | 22e. ADDRESS<br>Univ. of Md. HSP.                                          |                                                                                      |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                           |                                                                                                                                | 23b. DATE<br>6/9/79                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Memorial Park Baltimore   |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Md.                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.                                                                                                                                                                                                                       |                                                                                                                                |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                               |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>P. J. H. H.                                                       |  |

REPORT



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                         |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE Stephany SMITH</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 23 79</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>7:23A.M.</b>                                                                                                |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                                                                 |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 18, 1913</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                              |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                                           |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NECESSARY, GIVE FULL ADDRESS)<br><b>Church Hospital</b>                                                  |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sheet Metal Worker</b>                              |                                              |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Martin Co.</b>                                                                                                                                                                                                                                                                                                                                         |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland - Baltimore</b> |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                           |  | 13e. STREET ADDRESS<br><b>1116 N. Port Street</b>                                                                                                                       |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Yockel</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                         |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Runge</b>                                                                                          |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219 20 9225</b>                                                                                           |                                                       | 17. INFORMANT<br><b>Arthur C. Smith, Husband</b>                                                                                                            |  | ADDRESS<br><b>Same</b>                                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br><b>1749 CANCER OF THE BREAST WITH METASTASIS</b><br>IMMEDIATE CAUSE (a) <b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                                                         |                                                       |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                             |  |                                                                                                                                                                         |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                        |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                       |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                  |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 16</b> , 19 <b>79</b> , to <b>JUNE 23</b> , 19 <b>79</b> , that (I) (we) lost <b>6/23/79</b><br>saw the deceased alive on <b>JUNE 23</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |                                                                                                                                                                         |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22a. SIGNATURE<br><i>Dr. Walker Impagliatelli</i>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                         |                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>6/23/79</b>                                                                                         |                                              |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. WALKER IMPAGLIATELLI</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                         |                                                       | 22d. ADDRESS<br><b>CHURCH HOSPITAL</b>                                                                                                                      |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>6/26/79</b>                                                                                                                                             |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                                                    |                                              |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                         |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony M. Steady</i>                                                                     |                                              |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



1 4 0 1 2

1 4 0 1 2

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

|                  |                 |                 |    |
|------------------|-----------------|-----------------|----|
| Female           | White           | April 18, 1915  | 65 |
| Washington, D.C. | Law             |                 | x  |
| Attorney         | Charles H. Hays |                 |    |
| Harvard          | Attorney        |                 |    |
| Andrew           | James           |                 |    |
| 65               | April 18, 1915  | Charles H. Hays | 65 |

Handwritten notes and signatures are present in the lower half of the page, including a large signature that appears to read "John Edgar Hoover".



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
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(VR A15 ME (S))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14616

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                       |                                                 |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|-------------------------------------------------|
| FOR<br>1- STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 2a. DATE KNOWN<br>OF<br>DEATH                                                                                                         |                                                 | ESTI-<br>MATED                                                                                                                                              |  | MONTH<br>DAY<br>YEAR                                                                            |  | 2b. HOUR<br>M                                                                       |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                  | FIRST<br>David                                                                                                                        |                                                 | MIDDLE<br>O.                                                                                                                                                |  | LAST<br>Smith                                                                                   |  | 6 18 19 79 M                                                                        |                                                 |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-29-30                                                                                        | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>48 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS.<br>HOURS MIN                                                                   |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br>6 18 19 79 M                                      |                                                 |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>VA.                                                                                                                                                                                                                                                                                                                                                                                       |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                                                                                     |                                                 |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                                                                                                                               |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>MAINTENANCE                                                                             |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                            |  |                                                                                     |                                                 |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 13b. COUNTY                                                                                                                           |                                                 | 13c. CITY OR TOWN<br>BALTO.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>225 S. Oldham St.                                            |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Smith                                                                                                                                                                                                                                                                                                                                                                                   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena Gillespie                                                                       |                                                 |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                              |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korean                                                                     |                                                 | 17. INFORMANT<br>Mrs. David Williams                                                                                                                        |  | ADDRESS<br>3536 Noble                                                                           |  |                                                                                     |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Stab wound of chest<br>966-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                       |                  |                                                                                                                                       |                                                 |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                       |                                                 |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                     |                                                 |                                                                                                                                                             |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                      |                  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>11:15 M. 6 17 19 79                                                                     |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject stabbed by assailant                                               |  |                                                                                                 |  |                                                                                     |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                   |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>house                                                               |                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>525 S. Oldham St. Balto. MD                                                                            |  |                                                                                                 |  |                                                                                     |                                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                                                                       |                                                 |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                                 |
| ACTUAL<br>SIGNATURE<br>Hormez R. Guard                                                                                                                                                                                                                                                                                                                                                                                                    |                  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                     |                                                 | MEDICAL EXAMINER                                                                                                                                            |  | DATE<br>SIGNED 6/18/79                                                                          |  |                                                                                     |                                                 |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |                  | Hormez R. Guard, M.D.                                                                                                                 |                                                 | ADDRESS                                                                                                                                                     |  | 111 Penn St. Balto., MD                                                                         |  |                                                                                     |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |                  | 23b. DATE<br>6/21/79                                                                                                                  |                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cemetery                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                        |  |                                                                                     |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>ZANNINO Funeral Home                                                                                                                                                                                                                                                                                                                                                                                      |                  | ADDRESS<br>31224<br>263 S. Conkling                                                                                                   |                                                 | 25a. DATE REC'D. BY REGISTRAR<br>JUN 21 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Helen K. K...                                                     |  |                                                                                     |                                                 |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14617

|                                                                                                                                                                                                                                                                                                                        |         |                                                             |                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------|-------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                     |         | FOR                                                         |                   |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                        |         | 2a. DATE KNOWN OF DEATH                                     |                   |
| Donald JAMES Smith                                                                                                                                                                                                                                                                                                     |         | XX MONTH DAY YEAR 6 25 19 79                                |                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                            | 6. AGE (IN YEARS) |
| Male                                                                                                                                                                                                                                                                                                                   | White   | 09 22 34                                                    | 44 YRS.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                              |         | 7b. CITIZEN OF WHAT COUNTRY?                                |                   |
| MARYLAND                                                                                                                                                                                                                                                                                                               |         | USA                                                         |                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                              |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   |
| Baltimore City                                                                                                                                                                                                                                                                                                         |         | 32 N. Patterson Park                                        |                   |
| 12a. USUAL OCCUPATION (TYPE OF WORK)                                                                                                                                                                                                                                                                                   |         | 12b. KIND OF BUSINESS OR INDUSTRY                           |                   |
| BARTENDER                                                                                                                                                                                                                                                                                                              |         | CAFE                                                        |                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                             |         | 13b. COUNTY                                                 |                   |
| MARYLAND                                                                                                                                                                                                                                                                                                               |         | BALTIMORE                                                   |                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                      |         | 15. MOTHER'S MAIDEN NAME                                    |                   |
| SHERIDAN F. SMITH                                                                                                                                                                                                                                                                                                      |         | CATHERINE DEE                                               |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                           |         | 16b. SOCIAL SECURITY NO.                                    |                   |
| NO                                                                                                                                                                                                                                                                                                                     |         | 212309589                                                   |                   |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                          |         | ADDRESS                                                     |                   |
| MARY SELDIN                                                                                                                                                                                                                                                                                                            |         | 60 OLMSTEAD GREEN                                           |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                              |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |                   |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                            |         |                                                             |                   |
| IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u>                                                                                                                                                                                                                                                                          |         |                                                             |                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                         |         |                                                             |                   |
| (b) _____                                                                                                                                                                                                                                                                                                              |         |                                                             |                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                         |         |                                                             |                   |
| (c) _____                                                                                                                                                                                                                                                                                                              |         |                                                             |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                    |         |                                                             |                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |
|                                                                                                                                                                                                                                                                                                                        |         |                                                             |                   |
| 20. AUTOPSY?                                                                                                                                                                                                                                                                                                           |         |                                                             |                   |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                    |         |                                                             |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                    |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |                   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                                                                                                                                                                          |         |                                                             |                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                               |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |
| 21f. LOCATION                                                                                                                                                                                                                                                                                                          |         |                                                             |                   |
| 21g. CITY OR TOWN                                                                                                                                                                                                                                                                                                      |         | COUNTY                                                      |                   |
| 21h. STATE                                                                                                                                                                                                                                                                                                             |         |                                                             |                   |
| 22. I certify that I took charge of the remains described above, and on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . and in my opinion  |         |                                                             |                   |
| 22a. I certify that I took charge of the remains described above, and on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . and in my opinion |         |                                                             |                   |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                       |         | TITLE (SPECIFY)                                             |                   |
| Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                  |         | Deputy Chief                                                |                   |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                        |         | ADDRESS                                                     |                   |
| Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                  |         | 111 Penn St. Balto., MD.                                    |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                              |         | 23b. DATE                                                   |                   |
| BURIAL                                                                                                                                                                                                                                                                                                                 |         | 6/28/79                                                     |                   |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                     |         | 23d. LOCATION                                               |                   |
| WESTVIEW MEM. PARK                                                                                                                                                                                                                                                                                                     |         | BALTO.                                                      |                   |
| 23e. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                          |         | 23f. REGISTRAR'S SIGNATURE                                  |                   |
| JUN 28 1979                                                                                                                                                                                                                                                                                                            |         | [Signature]                                                 |                   |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                   |         | 25. DATE REC'D. BY REGISTRAR                                |                   |
| John J. Coach                                                                                                                                                                                                                                                                                                          |         | JUN 28 1979                                                 |                   |
| ADDRESS                                                                                                                                                                                                                                                                                                                |         | 25b. REGISTRAR'S SIGNATURE                                  |                   |
| 1211 Chesaco Ave.                                                                                                                                                                                                                                                                                                      |         | [Signature]                                                 |                   |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

Corrected Copy

REG. NO.

9 14618

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                      |                                                                                                                                                                              |  |                                                                                |  |                                                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frances Smith</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 21 79</b> |                                                                                                                                                                              |  | 2b HOUR<br><b>8:55p</b>                                                        |  |                                                                                                                           |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>✓</b>                                                                                                                            |                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 6 1909</b>                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS                                |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>                                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                         |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                      | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                    |  |                                                                                                                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                              |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Federal Hill Nursing Cntr.</b> |                                                      |                                                                                                                                                                              |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                                           |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                               |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                          |                                                      | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                               |  | 13e STREET ADDRESS<br><b>1213 Light Street</b>                                 |  |                                                                                                                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Harris</b>                                                                                                                                                                                                                                                                                                                                                |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Morahan</b>                                                                           |                                                      | 16 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>                                                                    |  |                                                                                |  |                                                                                                                           |  |
| 16a                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b SOCIAL SECURITY NO.<br><b>218-05-5624</b>                                                                                                 |                                                      | 17 INFORMANT<br>ADDRESS<br><b>Christine Browning 971 Cherry Hill Road</b>                                                                                                    |  |                                                                                |  |                                                                                                                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br><b>3314</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Low periperahl Hydrocephlous</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b> |  |                                                                                                                                               |                                                      |                                                                                                                                                                              |  |                                                                                |  |                                                                                                                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                                      |                                                                                                                                                                              |  |                                                                                |  |                                                                                                                           |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                      |                                                                                                                                                                              |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |                                                      | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                |  |                                                                                |  |                                                                                                                           |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                      | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                             |  |                                                                                |  |                                                                                                                           |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>12/20/78</b> , 19____, to <b>6/21/79</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>6/21/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                                               |  |                                                                                                                                               |                                                      |                                                                                                                                                                              |  |                                                                                |  |                                                                                                                           |  |
| 22b SIGNATURE<br><b>C. J. Folkemer</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                      | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                |  | 22c DATE SIGNED<br><b>6/21/79</b>                                                                                         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. J. Folkemer</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |                                                      | 22e ADDRESS<br><b>Federal Hill Nursing Home</b>                                                                                                                              |  |                                                                                |  |                                                                                                                           |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b DATE<br><b>6-26-79</b>                                                                                                                    |                                                      | 23c NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEM</b>                                                                                                                   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>VESPORT Md.</b>                |  | 23e                                                                                                                       |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Elickson Fnl. Home</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |                                                      | 24b ADDRESS<br><b>1129 W. Caroline</b>                                                                                                                                       |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                             |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or cause.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY H SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 28-79</b>                           |                                                                                      | 2b. HOUR<br>MIN<br><b>1:40 AM</b>                                                                                          |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>WHITE</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-10-1901</b>                                                                                                      |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTO. GEN. HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Realtor</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>                                                                    |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>BA.</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                                                                                               |                                                                                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | 13e. STREET ADDRESS <b>4302-Ritchie Highway, Baltimore, Md</b>                     |                                                                                      |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>S</b> LAST <b>SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>JULIA</b> MIDDLE <b>HECKER</b> LAST                                                                                    |                                                                                    |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>214-03-4196</b>                                                                                                 | 17. INFORMANT<br>ADDRESS <b>4302 Ritchie Hgwy Balto., Md 21225</b>                                                                                          |                                                                                    |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>ACUTE ANTEROLATERAL Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</b> |                                                                                                                                                |                                                                                                                                                             |                                                                                    |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>NONE</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION<br><b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (this hospital) attended the deceased from <b>6-27-1979</b> to <b>6-28-1979</b> , that (we) lost<br>saw the deceased alive on <b>6-28-1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.                                                                                                                                       |                                                                                                                                                |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | DEGREE <b>MD</b>                                                                                                                                            |                                                                                    | 22c. DATE SIGNED<br><b>6-28-79</b>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. ARDESHNA</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | 22e. ADDRESS<br><b>South Baltimore Gen. Hospital</b>                                                                                                        |                                                                                    |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                 | 23b. DATE<br><b>6/30/79</b>                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>                                                                                               |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hgwy, Balto</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                          |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |                                                                                                                            |

14313

HARRY H. SMITH

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Items #18a-22a Film G533 7/16/79 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14620

|                                                                                                                                                                                                      |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 1- REGISTRAR<br>FOR STATE                                                                                                                                                                            |  | 2a. DATE KNOWN OF DEATH                                                                                                            |  | MONTH DAY YEAR                                                                                                                                           |  | 7b. HOUR                                                                                     |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                      |  | 3. SEX                                                                                                                             |  | 4. RACE                                                                                                                                                  |  | 5. DATE OF BIRTH                                                                             |  |
| Howard O. Smith                                                                                                                                                                                      |  | male                                                                                                                               |  | black                                                                                                                                                    |  | 10 26 34                                                                                     |  |
| 6. AGE (IN YEARS)                                                                                                                                                                                    |  | IF UNDER 1 YR.                                                                                                                     |  | IF UNDER 24 HRS.                                                                                                                                         |  | 7c. DATE PRONOUNCED DEAD                                                                     |  |
| 44 YRS.                                                                                                                                                                                              |  | YES MONTHS DAYS                                                                                                                    |  | HOURS MIN.                                                                                                                                               |  | 6 14 19 79 10:47 a. M.                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |
| Va.                                                                                                                                                                                                  |  | USA                                                                                                                                |  |                                                                                                                                                          |  | Baltimore City MD.                                                                           |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |
| Baltimore                                                                                                                                                                                            |  | 2046 E. Preston Street                                                                                                             |  |                                                                                                                                                          |  |                                                                                              |  |
| 13a. STATE                                                                                                                                                                                           |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Md.                                                                                                                                                                                                  |  | Balto.                                                                                                                             |  | 2046 E. Preston St.                                                                                                                                      |  |                                                                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME                                                                                                           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                       |  | 16b. SOCIAL SECURITY NO.                                                                     |  |
| Arthur E. Smith                                                                                                                                                                                      |  | Mary H. Fore                                                                                                                       |  | Yes                                                                                                                                                      |  | 219-28-1716                                                                                  |  |
| 17. INFORMANT                                                                                                                                                                                        |  | ADDRESS                                                                                                                            |  | 17a. DATE OF OPERATION                                                                                                                                   |  | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                            |  |
| Mary Smith                                                                                                                                                                                           |  | 2046 E. Preston St.                                                                                                                |  |                                                                                                                                                          |  |                                                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |  | 18a. IMMEDIATE CAUSE (a)                                                                                                           |  | 18b. DUE TO, OR AS A CONSEQUENCE OF                                                                                                                      |  | 18c. DUE TO, OR AS A CONSEQUENCE OF                                                          |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |  | Multiple drug intoxication                                                                                                         |  |                                                                                                                                                          |  |                                                                                              |  |
| 9505                                                                                                                                                                                                 |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                      |  |                                                                                                                                                          |  |                                                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                  |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |  |                                                                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH?                                                                      |  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR                                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                              |  |
|                                                                                                                                                                                                      |  | P.M. 6/13/ 1979                                                                                                                    |  | self ingested                                                                                                                                            |  |                                                                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                        |  | 21f. LOCATION                                                                                                                                            |  |                                                                                              |  |
|                                                                                                                                                                                                      |  | home                                                                                                                               |  | 2046 E. Preston St. Baltimore Maryland                                                                                                                   |  |                                                                                              |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                                                                                       |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | TITLE (SPECIFY)                                                                                                                                          |  | DATE SIGNED                                                                                  |  |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                    |  | M.D. Assistant                                                                                                                                           |  | 6/14/79                                                                                      |  |
| ACTUAL SIGNATURE                                                                                                                                                                                     |  | Hormez R. Guard, M.D.                                                                                                              |  | ADDRESS                                                                                                                                                  |  | 111 Penn Street, Baltimore, MD 21201                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                            |  | 23b. DATE                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                                                |  |
| Burial                                                                                                                                                                                               |  | 6/19/79                                                                                                                            |  | Baltimore Cem.                                                                                                                                           |  | Baltimore, Md.                                                                               |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                            |  | ADDRESS                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |
| Wm C March F/H                                                                                                                                                                                       |  | 1101 E. North Ave.                                                                                                                 |  | JUN 18 1979                                                                                                                                              |  | [Signature]                                                                                  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

1. 2. 3. 4. 5. 6. 7.



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9

14621

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                  |                                                                                                                                                            |                                                                               |                                                                                      |                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MABEL -M. SMITH                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                  |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 07 79                               |                                                                                      | 2b. HOUR<br>8:15 AM                                           |
| 3 SEX<br>F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4 RACE<br>W.                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>07 16 1892                                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 <del>87</del> YRS.                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                            |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                      |                                                                                      |                                                               |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montebello Hospital |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home                                         |                                                               |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13b. COUNTY<br>Baltimore                                                                                                         | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            | 13d. STREET ADDRESS<br>216 W. Monument St. 21201                              |                                                                                      |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Hall                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown                                                                                                   |                                                                               |                                                                                      |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>-                                                                                                    | 17. INFORMANT<br>Charles J. Smith, Jr. 216 W. Monument St. 21201                                                                                           |                                                                               |                                                                                      |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute Pneumonia (Aspiration)</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CA of the Colon and Colostomy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs<br>5 Yr. |                                                                                                                                  |                                                                                                                                                            |                                                                               |                                                                                      |                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Cholecystitis, Gall Stone, multiple pressure sores, old age</u>                                                                                                                                                                                                                                                           |                                                                                                                                  |                                                                                                                                                            |                                                                               |                                                                                      |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                               |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                  |                                                                                                                                                            |                                                                               |                                                                                      |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                    |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/23/1979</u> to <u>6/7/1979</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/7/1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                      |                                                                                                                                  |                                                                                                                                                            |                                                                               |                                                                                      |                                                               |
| 22b. SIGNATURE<br>Khosrow Esna                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                  | DEGREE<br>M.D.                                                                                                                                             |                                                                               | 22c. DATE SIGNED<br>6/7/79                                                           |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KHOSROW ESNA                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                  | 22e. ADDRESS<br>Montebello Hospital<br>2201 Argonne DR. Baltimore, Md. 21218                                                                               |                                                                               |                                                                                      |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                  | 23b. DATE<br>6-11-1979                                                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Hill Free Burial                   |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balt. Balt. Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. J. Cowan, Jr. 901 Hollins St.                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                  | ADDRESS<br>Balt. Md. 21223                                                                                                                                 |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                         | 25b. REGISTRAR'S SIGNATURE<br>Harry McInerney                 |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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OFFICE OF THE  
STATE ENGINEER  
STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                        |                                                             |                                                                                                                                                             |                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARTHA SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 6 4 1979</b> |                                                                                                                                                             | 2b. HOUR<br><b>6 A.M.</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Negro</b>                                                |                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 20 1899</b>                                                                                                   |                           |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b> YRS                                                                                                                                                                                                                                                                                                                                                                                                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                         |                                                             | IF UNDER 24 HRS<br>HOURS MIN.                                                                                                                               |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                           |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                          |                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>701 Allendale Street</b>                    |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self employed</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |                                                             |                                                                                                                                                             |                           |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                           |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                        |  | 13e. STREET ADDRESS<br><b>701 Allendale St. 21229</b>                  |                                                             |                                                                                                                                                             |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Northfleet Gray</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie Gray</b>    |                                                             |                                                                                                                                                             |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>218-38-3623</b>                         |                                                             | 17. INFORMANT<br>ADDRESS<br><b>Vernal Bryan/702 Mt. Holly St. 21229</b>                                                                                     |                           |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>ATRIAL FIBRILLATION</b><br>(c) <b>Atherosclerotic Cardiovascular Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b><br><b>4 months</b><br><b>(years)</b> |  |                                                                        |                                                             |                                                                                                                                                             |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |                                                             |                                                                                                                                                             |                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                           |  |
| 22a. I certify that (a) this hospital attended the deceased from <b>June 1978</b> to <b>June 4, 1979</b> , that (b) I saw the deceased alive on <b>May 28, 1979</b> , and that in my (c) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)                                                                                                                                            |  |                                                                        |                                                             |                                                                                                                                                             |                           |  |
| 22b. SIGNATURE<br><b>Frederic T. Farra, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                    |                                                             | 22c. DATE SIGNED<br><b>6/4/79</b>                                                                                                                           |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERIC T. FARRA, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>UNW OF MD HOSPITAL</b>                              |                                                             |                                                                                                                                                             |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>06/08/79</b>                                           |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                                                                                          |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Baltimore Md.</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                     |                                                             | 23f. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>                                                                                                         |                           |  |
| 24. FUNERAL DIRECTOR<br><b>Marshall W. Jones, Jr. F.H. P.A.</b><br><b>4101 Edmondson Avenue, Baltimore, Md. 21229</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |                                                             |                                                                                                                                                             |                           |  |

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RECEIVED  
DEPT. OF AGRICULTURE  
WASHINGTON, D. C.





FOR  
- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PAUL W. SMITH                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 19 79 |                                                                                                                                                             |  | 2b. HOUR<br>4:00P.M.                                                                                                       |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>WHITE                                                                                                                     |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 02 04                                                                                                              |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>74 YRS                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>INDIANA                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MARYLAND                                                                              |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>BALTIMORE                                                                                                             |                                                 | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER I. SCHDOWNSKI                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BERTHA ANNIS                                                                        |                                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                       |  | 17. SOCIAL SECURITY NO<br>213-10-4037                                                                                      |  |
| 18. INFORMANT<br>PAUL D. SMITH, P.O. BOX 507, SUNSET BEACH                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br>PASADENA, MD.                                                                                                             |                                                 | 19. STREET ADDRESS<br>1221 W. OSTEND STREET, 21230                                                                                                          |  | 20. MATCH CO.                                                                                                              |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u><br>1889<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bladder Cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> 19 <u>79</u> to <u>6/29</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/19</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                               |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>DAT PHAM</u>                                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                                               |                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>6-19-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAT PHAM                                                                                                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL                                                                                              |                                                 |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>06-22-79                                                                                                                |                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>SPRINGFIELD CEM.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SYKESVILLE CARROLL MD.                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br>21229                                                                                                                     |                                                 | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barney McHenry</u>                                                                        |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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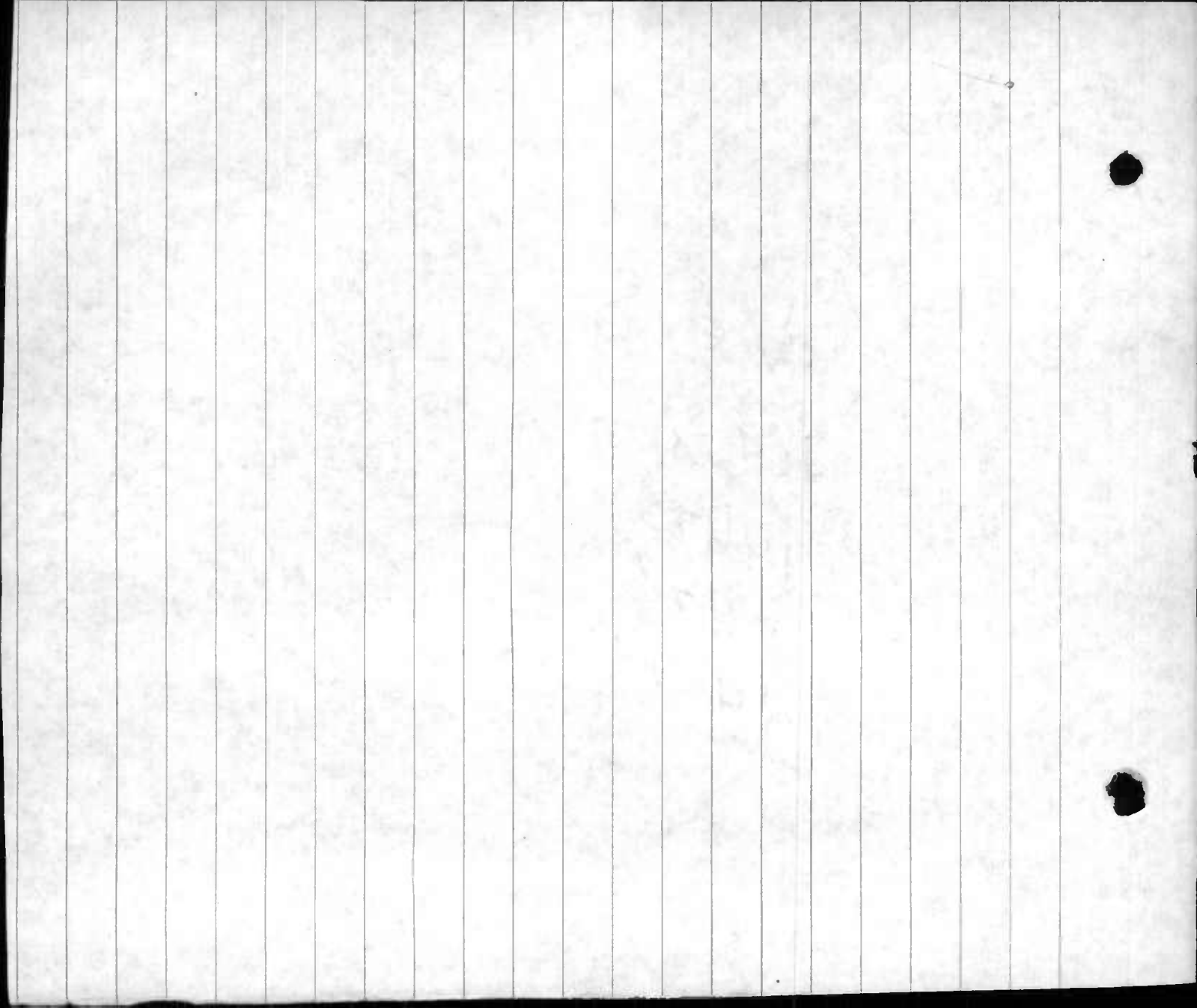
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

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| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                            |  | FIRST MIDDLE LAST<br>WALTER WILLIAM SMITH                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6-19-79                                                                                |  | 2b. HOUR<br>1:15 A.M.                                                   |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>WHITE                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 05 04                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS                                                                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>STERLING AUTO                                                                         |  |                                                                         |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br>BALTIMORE                                                                                                       |  | 13c. CITY OR TOWN<br>CATONSVILLE                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>RADIATOR WORKS<br>1208 WESTERLEE PLACE, APT. 1 B |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER E. SMITH                                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HENRIETTA R. SCOTT                                                            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                      |  | 16b. SOCIAL SECURITY NO<br>215-01-6902                                                                                     |  | 17. INFORMANT ADDRESS<br>EDNA E. SMITH, 1208 WESTERLEE PLACE, 21228     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARRYTHMIA</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION</u> 48 H.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                         |  |
| 19a. DATE OF OPERATION<br>6-18-79                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ABDOMINAL EVISCERATION                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)                                                                              |  |                                                                                                                            |  |                                                                         |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-29 1979 to 6-19 1979, that (I) (we) last saw the deceased alive on 6-19-79 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                         |  |
| 22b. SIGNATURE<br>M. H. Budeir                                                                                                                                                                                                                                                                                                                                                                                                        |  | DEGREE<br>M.D.                                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>6-19-79                                                                                                |  |                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. H. Budeir, M.D.                                                                                                                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>06-22-79                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                                                      |  |                                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br>4107 WILKENS AVE.                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>H. J. McBrady                                                                                |  |                                                                         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 7/781- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 2 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                            |                                                                                   |                                                                                                |                                                      |                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARVEY ALEXANDER SMOTHERS</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6/28/79</b>                              |                                                                                                | 2b HOUR<br><b>6:45 A</b>                             |                                                                                                                           |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                     | 4 RACE<br><b>Col.</b>                                                                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/ 26/ 16</b>                                                                                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b><br>YRS                                | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>62</b>                                                     |                                                      | # UNDER 24 HRS<br>HOURS MIN<br><b>62</b>                                                                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                              | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                   |                                                                                                |                                                      |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore, Md</b>                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2702 Classen Ave. 21215</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                     |                                                                                                                           |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                             | 13b COUNTY                                                                                                                                                 | 13c CITY OR TOWN<br><b>Baltimore</b>                                              | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>2702 Classen Ave. 21215</b> |                                                                                                                           |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rodney A. Smothers</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Murray</b>                                                                                       |                                                                                   |                                                                                                |                                                      |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                        | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>                                                                      | 17 INFORMANT ADDRESS<br><b>Mrs. Maurita Smothers-2702 Classen Av.</b>                                                                                      |                                                                                   |                                                                                                |                                                      |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>185-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>of prostate - 2 years</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                             |                                                                                                                                                            |                                                                                   |                                                                                                |                                                      |                                                                                                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                            |                                                                                   |                                                                                                |                                                      |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                             | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |                                                                                                                                             | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                      |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                            |                                                                                                                                             | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                      |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                               |                                                                                                                                             |                                                                                                                                                            |                                                                                   |                                                                                                |                                                      |                                                                                                                           |
| 22b SIGNATURE<br><b>Rex T Averill MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                            |                                                                                   | 22c DATE SIGNED<br><b>6/29/79</b>                                                              |                                                      |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rex T Averill MD</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                            |                                                                                   | 22e ADDRESS<br><b>Koch Raven VAH, Balt. Md</b>                                                 |                                                      |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                | 23b DATE<br><b>7/2/79</b>                                                                                                                   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                                                                                               |                                                                                   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |                                                      |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Russ</b> ADDRESS<br><b>-2222-26 W. North Av.</b>                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                            |                                                                                   | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                              |                                                      |                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                            |                                                                                   | 25b REGISTRAR'S SIGNATURE<br><b>H. J. Kennedy</b>                                              |                                                      |                                                                                                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14630

REG. NO.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lillie Sneld</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 28 79</b>                                                                                                       |  | 2b. HOUR<br><b>2:00PM</b>                                                            |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>BLACK</b>                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 2 94</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b><br>YRS MONTHS DAYS HRS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALD CITY</b> MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY 14050 15AL</b> |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                             |  | 13c. STREET ADDRESS<br><b>3004 GLEN AVE.</b>                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                             |  |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>215-14-8558</b>                                                                                                              |  | 17. INFORMANT ADDRESS<br><b>KATHERINE GREEN 3004 GLEN AVE.</b>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SEPSIS</b><br><b>436 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>URINARY TRACT INFECTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>S/P CVA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WKS</b><br><b>2-3 WKS</b> |                                                                                                                                      |                                                                                                                                                             |  |                                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>A3 CVD</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                             |  |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/19/79</b> 19____ to <b>6/28/79</b> 19____, that (I) (we) last saw the deceased alive on <b>6/28/79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                |                                                                                                                                      |                                                                                                                                                             |  |                                                                                      |  |
| 22b. SIGNATURE<br><b>Jerome Snyder MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | DEGREE                                                                                                                                                      |  | 22c. DATE SIGNED<br><b>6/29/79</b>                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jerome Snyder MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 22e. ADDRESS<br><b>Mercy Hospital BALD. MD.</b>                                                                                                             |  |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 23b. DATE<br><b>6/30/79</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN</b>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 9 1979</b>                                                                                                          |  |                                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ph. 11125 1721-27 N. MONROE ST.</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                            |  |                                                                                      |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

00001 P.T.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elsie Snipe</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-28-79</b> |                                                                                                                                                            |  | 2b HOUR<br><b>6:45 P.M.</b>                                                                                                |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>Black</b>                                                                                                                |                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-17-03</b>                                                                                                        |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                                                           |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |                                                      | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Ruxton</b> |                                                      |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                            |  |
| 12b KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b COUNTY<br><b>Balto.</b>                                                                                                           |                                                      | 13c CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 13e STREET ADDRESS<br><b>5509 Lothian Rd.</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Efrom Bostick</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                      | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unkn</b>                                                                                                |  |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                          |  | 16b SOCIAL SECURITY NO.                                                                                                               |                                                      | 17. INFORMANT<br>ADDRESS<br><b>Booker T. Snipe 5509 Lothian Rd.</b>                                                                                        |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Heart Failure due to</b><br><b>4409</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atherosclerosis Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Gastrostomy Tube</b> |  |                                                                                                                                       |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                      | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                  |  |                                                                                                                                       |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Walter Kees M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |                                                      | DEGREE<br><b>M.D.</b>                                                                                                                                      |  | 22c. DATE SIGNED<br><b>6-28-79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter Kees M.D.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                      | 22e. ADDRESS                                                                                                                                               |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>7/6/79</b>                                                                                                            |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>                                                 |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |                                                      | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>                                                                                                        |  |                                                                                                                            |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 5 0 4 1 8 7



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 79 1 4 6 3 2                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | REG. NO.                                                                                                                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUSSELL BB. B. SONIA                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br>6 13 79                                                                                       |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>6:44 PM                                                                                                                  |  |
| 4. RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 13 79                                                                                        |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>1 18 hr                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS                                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HHC Aberdeen Proving Ground                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Harford A.P.G.                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>—                                                                                                        |  |
| 17. INFORMANT<br>ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u><br><u>2762</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE RESPIRATORY ACIDOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>EXTREME PREMATUREITY</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79                                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/4/79</u> to <u>3/13/79</u> , that (I) (we) lost saw the deceased alive on <u>3/13/79</u> 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                         |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>Sonia</u>                                                                                                       |  |
| 22c. DATE SIGNED<br>6/13/79                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAROS MENTA                                                                                 |  |
| 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 23b. DATE                                                                                                                            |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 25a. DATE AND TIME OF REGISTRATION<br>JUN 18 1979                                                                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                      |  |

MEDICAL CERTIFICATION

23041 87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14633

|                                                                                                                                                                                                                                                                                                                             |         |                                                             |                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------|-------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                          |         | FOR                                                         |                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                            |         | 2a. DATE KNOWN OF DEATH                                     |                   |
| Michael Harry Spahn                                                                                                                                                                                                                                                                                                         |         | xx MONTH DAY YEAR 6 14 19 79                                |                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                      | 4. RACE | 5. DATE OF BIRTH                                            | 6. AGE (IN YEARS) |
| Male                                                                                                                                                                                                                                                                                                                        | White   | 6 23 59                                                     | 19 YRS.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   |         | 7b. CITIZEN OF WHAT COUNTRY?                                |                   |
| MD                                                                                                                                                                                                                                                                                                                          |         | USA                                                         |                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   |
| Baltimore City                                                                                                                                                                                                                                                                                                              |         | University Hospital                                         |                   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                               |         | 12b. KIND OF BUSINESS OR INDUSTRY                           |                   |
| PAINT CO.                                                                                                                                                                                                                                                                                                                   |         | -                                                           |                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  |         | 13c. CITY OR TOWN                                           |                   |
| MD                                                                                                                                                                                                                                                                                                                          |         | ESSEX                                                       |                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |         | 15. MOTHER'S MAIDEN NAME                                    |                   |
| HARRY I. SPAHN                                                                                                                                                                                                                                                                                                              |         | DARLEEN V. HEWITT                                           |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                          |         | 16b. SOCIAL SECURITY NO.                                    |                   |
| NO                                                                                                                                                                                                                                                                                                                          |         | 217-62-7325                                                 |                   |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                               |         | ADDRESS                                                     |                   |
| HARRY I SPAHN                                                                                                                                                                                                                                                                                                               |         | ABOVE                                                       |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |         |                                                             |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                         |         |                                                             |                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                           |         | 21b. TIME OF INJURY                                         |                   |
| 21d. INJURY OCCURRED WHILE AT WORK                                                                                                                                                                                                                                                                                          |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                                                                                                                               |         | 21f. LOCATION                                               |                   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Accident X                                                                                                                                                                                                                   |         | 22b. TITLE (SPECIFY)                                        |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   |         | 23b. DATE                                                   |                   |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                          |         | 23d. LOCATION                                               |                   |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                        |         | 25a. DATE REC'D. BY REGISTRAR                               |                   |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                  |         |                                                             |                   |

MEDICAL CERTIFICATION

1

3

5

13

2

BP

Hormez R. Guard, M.D. 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION  
 24. FUNERAL DIRECTOR 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
 CONNELLY E.H. 300 MYCE AVE JUN 19 1979

20041 87

100

100

100





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 6 3 4

|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                  |                                                                                      |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EARL O SPRIGGS                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 28, 1979             |                                                                                      | 2b. HOUR<br>6:53A                            |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>Negro                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 11, 1936                                                                                                        |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.                                                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                |                                                                                                                                         |                                                                                                                                                             | 13b. COUNTY                                                      | 13c. CITY OR TOWN<br>Baltimore                                                       |                                              |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             | 13e. STREET ADDRESS<br>1210 H Court                              |                                                                                      |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Stewart                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eleanor Spriggs                                                                                            |                                                                  |                                                                                      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                  | 17. INFORMANT<br>ADDRESS<br>Eleanor Spriggs 3233 Ravenwood                           |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br><u>4239</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiac Tamponade</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Systemic Illness</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                         |                                                                                                                                                             |                                                                  |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             |                                                                  |                                                                                      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             |                                                                  |                                                                                      |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                         |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>79</u> , to <u>6/28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.                                                      |                                                                                                                                         |                                                                                                                                                             |                                                                  |                                                                                      |                                              |
| 22b. SIGNATURE<br><u>P.D. Scanlon</u>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | DEGREE<br><u>MD</u>                                                                                                                                         |                                                                  | 22c. DATE SIGNED<br><u>6/28/79</u>                                                   |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Paul D. Scanlon</u>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 22e. ADDRESS<br><u>Johns Hopkins Hosp Balto Md 21205</u>                                                                                                    |                                                                  |                                                                                      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         | 23b. DATE<br><u>7/1/79</u>                                                                                                                                  |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.                              |                                              |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Md.                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             |                                                                  |                                                                                      |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F.H./1101                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | ADDRESS<br>E. North Ave.                                                                                                                                    |                                                                  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><u>Barbara K. Brooks</u>                                                                                                      |                                                                  |                                                                                      |                                              |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 8 8 4 1 9 7



Spriggs, Edith

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 3 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                    |                                                                                       |                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EDITH SPRIGGS                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 7 1979 |                                                                                       | 2b. HOUR<br>645A M |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>Black                                                                                                                     |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 10 06                                         |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                             |                    |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                            |                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>Balto.                                                                                                                |                                                    | 13c. CITY OR TOWN<br>Balto.                                                           |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anderson Goldston                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jennir Young                                                                        |                                                    | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>911 Northhill Rd. |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-10-2748                                                               |                                                    | 17. INFORMANT<br>ADDRESS<br>Wm Spriggs 911 Northhill Rd.                              |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>myocardial arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>coronary heart disease</u> |  |                                                                                                                                      |                                                    |                                                                                       |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>obesity Adult onset diabetes mellitus mild anemia</u>                                                                                                                                                                                                          |  |                                                                                                                                      |                                                    |                                                                                       |                    |  |
| 19a. DATE OF OPERATION<br>None                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-                                                                                |                                                    | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/31</u> 19 <u>79</u> to <u>6/7</u> 19 <u>79</u> , that (1) (we) lost<br>saw the deceased alive on <u>6/7</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death.                                             |  |                                                                                                                                      |                                                    |                                                                                       |                    |  |
| 22b. SIGNATURE<br><u>Robert A. Varady MD</u>                                                                                                                                                                                                                                                                                                                                                              |  | DEGREE<br>MD                                                                                                                         |                                                    | 22c. DATE SIGNED<br>6/7/79                                                            |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT A. VARADY                                                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br>Univ. of Md. Hospital Family Practice, Baltimore, Md.                                                                |                                                    |                                                                                       |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>6/12/79                                                                                                                 |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat. Mem. Pk.                               |                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel, Md.                                                                                                                                                                                                                                                                                                                                                 |  | 25a. DATE REC'D BY REGISTRAR<br>JUN 11 1979                                                                                          |                                                    |                                                                                       |                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br>1101 E. North Ave.                                                                                                        |                                                    |                                                                                       |                    |  |

0901 BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

28041 87



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS AFTER DEATH. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14636  
REG. NO.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                     |  |                          |  |                                                                                                                                              |  |                                                                                              |  |                                                                                                                                                          |                            | REG. NO. 14636                                                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WALTER PATTON SPRINKLE, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                          |  |                                                                                                                                              |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <b>6 23 19 79</b>                                        |  | 2b. HOUR <b>3:08</b>                                                                                                                                     |                            | 2c. DATE PRONOUNCED DEAD <b>6 23 19 79</b>                                       |  |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE <b>white</b>     |  | 5. DATE OF BIRTH <b>5/31/19</b>                                                                                                              |  | 6. AGE (IN YEARS) <b>60</b>                                                                  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                 |                            | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Florida</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                   |  |                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                       |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>620 N. Eutaw Street 2nd floor</b> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>                                                                           |                            | 12b. KIND OF BUSINESS OR INDUSTRY <b>Beth.Steel</b>                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                             |  |                          |  |                                                                                                                                              |  |                                                                                              |  |                                                                                                                                                          |                            |                                                                                  |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY <b>-</b>     |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3725 Elmora Avenue 21213</b>                                                                                                      |                            |                                                                                  |  |
| 14. FATHER'S NAME <b>John Sprinkle</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                          |  |                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME <b>Lizzie Woodland</b>                                              |  |                                                                                                                                                          |                            |                                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                          |  | 16b. SOCIAL SECURITY NO. <b>402-12-4906</b>                                                                                                  |  | 17. INFORMANT ADDRESS <b>Walter P.Sprinkle,Jr.(son) same as 1</b>                            |  |                                                                                                                                                          |                            |                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                             |  |                          |  |                                                                                                                                              |  |                                                                                              |  |                                                                                                                                                          |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                                         |  |                          |  |                                                                                                                                              |  |                                                                                              |  |                                                                                                                                                          |                            |                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                            |  |                                                                                              |  |                                                                                                                                                          |                            | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |                                                                                                                                                          |                            |                                                                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                                          |                            |                                                                                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                          |  |                                                                                                                                              |  |                                                                                              |  |                                                                                                                                                          |                            |                                                                                  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                          |  |                                                                                                                                              |  | TITLE (SPECIFY) <b>Assistant</b>                                                             |  |                                                                                                                                                          | DATE SIGNED <b>6/23/79</b> |                                                                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                          |  |                                                                                                                                              |  | ADDRESS <b>111 Penn Street</b>                                                               |  |                                                                                                                                                          |                            |                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE <b>6/28/79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>                                                                                   |  | 23d. LOCATION CITY OR TOWN <b>Baltimore,</b>                                                 |  | COUNTY <b>Md.</b>                                                                                                                                        |                            | STATE                                                                            |  |
| 24. FUNERAL DIRECTOR <b>Schamunek Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                          |  |                                                                                                                                              |  | ADDRESS <b>3331 Brehms Lane Balto. Md. 21213</b>                                             |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>                                                                                                         |                            | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |  |

05041 87



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Division of Vital Records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Time 1 6533 7/9/79 gj

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 1

1 4 6 3 7

|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                            |                                                                     |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Delbert W. Stafford</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 25 79</b>               |                                                                                      | 2b. HOUR<br>M<br><b>M</b>                                                                                                  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br><b>Black</b>                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 20 14</b>                                                                                                       |                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b><br>YRS MONTHS DAYS HOURS MIN.            |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>454 Litchester Ave.</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                            | 13b. COUNTY                                                         | 13c. CITY OR TOWN<br><b>Balto.</b>                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Donald Stafford</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clora Miller</b> |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><b>243-01-9470</b>                                                                                                             |                                                                     | 17 INFORMANT<br>ADDRESS<br><b>Vivian P. Stafford 454 Litchester Ave.</b>             |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARRHYTHMIA'S</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 YRS</b> |                                                                                                                                         |                                                                                                                                                            |                                                                     |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS</b><br><b>5 YRS</b>                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                        |                                                                                                                                         |                                                                                                                                                            |                                                                     |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (1) <del>the deceased</del> attended the deceased from <b>OCT 78</b> to <b>JUNE 25 79</b> , that (1) <del>we</del> lost saw the deceased alive on <b>JUNE 79</b> , and that in (my) <del>opinion</del> death occurred on the date and hour and from the causes stated above; (1) <del>we</del> (did not) view the body after death.                                    |                                                                                                                                         |                                                                                                                                                            |                                                                     |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>Dennis J. Chodnicki</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | DEGREE                                                                                                                                                     |                                                                     | 22c. DATE SIGNED<br><b>6-27-79</b>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DENNIS CHODNICKI</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 22e. ADDRESS<br><b>201 E. UNIV. BLVD. UNION MEMORIAL HOSP.</b>                                                                                             |                                                                     |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 23b. DATE<br><b>6/30/79</b>                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>          |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                                                    |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                       |                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard M. Brady</b>                                                                      |

14031 79

1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 1 4 6 3 8

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                             |                                                                                                                                                        |                                                                                                                                                            |                                                                                                |                                                               |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE R. STALLINGS</b>                                                               |                                                                                                                                                        |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH <b>6</b> DAY <b>9</b> YEAR <b>79</b>                                 |                                                               | 2b HOUR<br><b>12:22P</b><br>M                            |
| 3 SEX<br><b>MALE</b>                                                                                                        | 4 RACE<br><b>WHITE</b>                                                                                                                                 | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>19</b> YEAR <b>02</b>                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b><br>YRS.                                            |                                                               | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                           | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE, CITY</b> MD.                       |                                                               |                                                          |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, 3900 LOCH RAVEN BLVD., 21218</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffeur</b>            |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Taxi Cab Co.</b> |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b> | 13b COUNTY<br><b>-----</b>                                                                                                                             | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>836 GLADE CT., BALTO., MD. 21225</b> |                                                          |
| 14 FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>W.</b> LAST <b>Stallings</b>                                              | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Sarah</b> MIDDLE <b>F.</b> LAST <b>Richert</b>                                                                     |                                                                                                                                                            |                                                                                                |                                                               |                                                          |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                           | (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>                                                                                                             | 16b SOCIAL SECURITY NO.<br><b>213 05 7982</b>                                                                                                              | 17 INFORMANT<br><b>Mrs. Nellie R. Stallings 836 Glade Court Baltimore, Maryland 21225</b>      |                                                               |                                                          |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

0388  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Sepsis/Septicemia (Serratia)**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Cold Agglutination Hemolytic Anemia**

|                                                                                                                                                                                                                                                                                                                                                               |                                                                       |                                                                                                                                            |                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                                                              |                                                                                                                               |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                 | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET <b>3900 LOCH RAVEN BLVD., BALTO. MD. 21218</b><br>CITY OR TOWN COUNTY STATE                                         |                                                                                                                               |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>4-19</b> 19 <b>79</b> to <b>6-9</b> 19 <b>79</b> , that if (we) lost<br>saw the deceased alive on <b>6-9</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (b) (we) (did) <b>not</b> view the body after death. |                                                                       |                                                                                                                                            |                                                                                                                               |
| 22b SIGNATURE<br><b>Richard Fastigius, MD</b>                                                                                                                                                                                                                                                                                                                 | DEGREE                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>6-10-79</b>                                                                                            |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Fastigius, MD</b>                                                                                                                                                                                                                                                                                          | 22e ADDRESS<br><b>Loch Raven VAMH Balt., MD.</b>                      |                                                                                                                                            |                                                                                                                               |

|                                                                       |                             |                                                                   |                                                                          |
|-----------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>         | 23b. DATE<br><b>6/13/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cheltenham Vet. Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheltenham Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mc Cully Funeral Home of Brooklyn</b> |                             | 24b. ADDRESS<br><b>Balto., Md. 21225</b>                          | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                      |                             |                                                                   |                                                                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8 3 3 1 9 7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 6 3 9

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   |                                                                                                                                                             |                                                                         |                                                                                                |                                                                                                                            |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                   | FIRST<br>SAMUEL                                                                                                                                             | MIDDLE<br>E                                                             | LAST<br>STAMATHIS                                                                              | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>6 - 30 1979                                                                          | 11:30A.<br>M                |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                          | 4 RACE<br>White                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 10 15                                                                                                               |                                                                         | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS                                                                |                             |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida                                                                                                                                                                                                                                                                                                                    | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                      |                                                                                                                            |                             |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hospital |                                                                                                                                                             |                                                                         | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Photographer                | 12b KIND OF BUSINESS OR INDUSTRY<br>Photography                                                                            |                             |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.                                                                                                                                                                                                                                                        |                                                                                                                                   | 13b COUNTY                                                                                                                                                  | 13c CITY OR TOWN<br>Baltimore                                           | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>3211 Eastern Avenue                                                                                  |                             |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Emmanuel Samuel Stamathis                                                                                                                                                                                                                                                                                                     |                                                                                                                                   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Georgakis                                                                                              |                                                                         |                                                                                                |                                                                                                                            |                             |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                             |                                                                                                                                   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II                                                                                             |                                                                         | 17 INFORMANT<br>Mrs. Kiki Stamathis, 3211 Eastern Avenue<br>Baltimore, Md.                     |                                                                                                                            |                             |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MALNUTRITION AND EMACIATION<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF, ATHEROSCLEROTIC HEART<br>DISEASE WITH OLD MYOCARDIAL INFARCTION<br>(b) AND CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF, CHRONIC BRONCHITIS<br>(c) |                                                                                                                                   |                                                                                                                                                             |                                                                         |                                                                                                |                                                                                                                            |                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                     |                                                                                                                                   |                                                                                                                                                             |                                                                         |                                                                                                |                                                                                                                            |                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                 |                                                                                                                            |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                           |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                              |                                                                                                                            |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 26 1979, to JUNE 30 1979, that (I) (we) lost saw the deceased alive on JUNE 30 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death.)                                                     |                                                                                                                                   |                                                                                                                                                             |                                                                         |                                                                                                |                                                                                                                            |                             |
| 22b. SIGNATURE<br>H. Al-Midani                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                   |                                                                                                                                                             |                                                                         | DEGREE<br>M.D.                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br>6/30/79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Al-Midani                                                                                                                                                                                                                                                                                                                  |                                                                                                                                   |                                                                                                                                                             |                                                                         | 22e. ADDRESS<br>Church Hospital                                                                |                                                                                                                            |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                    |                                                                                                                                   | 23b. DATE<br>7-3-79                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Orthodox Cemetery Baltimore |                                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md.                                                      |                             |
| 24 FUNERAL DIRECTOR<br>NAME<br>Nicholas T. Matthews, 3021 Eastern Ave., Balto.                                                                                                                                                                                                                                                                                         |                                                                                                                                   |                                                                                                                                                             |                                                                         | 25a. DATE REC'D. BY REGISTRAR<br>JUL 9 1979                                                    |                                                                                                                            |                             |
|                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   |                                                                                                                                                             |                                                                         | 25b. REGISTRAR'S SIGNATURE<br>R. Kelly                                                         |                                                                                                                            |                             |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                                                  |                                                                                      |                                                     |                                                                                                                            |  | REG. NO. 79 14640                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Robert STANDIFORD</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 11 79</b>                                                                                                            |                                                                                      |                                                     | 2b. HOUR<br><b>1:20 P. M.</b>                                                                                              |  |                                                                                                      |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>Caucasian</b>                                                                                                             |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 5 15</b>                                                                                                        |                                                                                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                    |                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4502 N. Charles St.</b> |                                                                        |                                                                                                                                                             |                                                                                                                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b>      |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Service Sta.</b>                                                                   |  |                                                                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Baltimore</b>                                                                                                                                                                                                                                   |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                             |                                                                                      | 13e. STREET ADDRESS<br><b>5306 Kennelworth Ave</b>  |                                                                                                                            |  |                                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin F. Standiford</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary M. Sanders</b>                                                                                          |                                                                                      |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>WWII</b>                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>216-18-6793</b>                                                                                          |                                                                        | 17. INFORMANT ADDRESS<br><b>Mrs. Marie O. Staniford, 5300 Kenilworth Ave.</b>                                                                               |                                                                                                                                                                  |                                                                                      |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ventricular fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MIASCUM</b> |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                                                  |                                                                                      |                                                     |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>Seconds</b><br><b>10 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Alcoholic cardiomyopathy</b>                                                                                                                                                                                                                                  |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                                                  |                                                                                      |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , 19 <b>67</b> , to <b>6/11</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                                                  |                                                                                      |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 22b. SIGNATURE<br><b>Lee E. Gresser M.D.</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      |                                                     |                                                                                                                            |  | 22c. DATE SIGNED<br><b>6/11/79</b>                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lee E. GRESSER M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>4502 N. Charles St.</b>                                                                                                                       |                                                                                      |                                                     |                                                                                                                            |  |                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         | 23b. DATE<br><b>6/14/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                                    |                                                                                      |                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea Balto. Md.</b>                                                    |  |                                                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc., 6500 York Rd.</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                                                                                                              |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b> |                                                                                                                            |  |                                                                                                      |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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STATE  
REGISTRAR

REG. NO.

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| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GRACE I. STANLEY                                                                                                                                                                                                                                                                                                                                             |                                                                                                                         |                                                                                                                                                 | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>06 18 79                                      |                                                                               | 2b HOUR<br>12:45 AM              |                                                                                                                              |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                              | 4 RACE<br>BLACK                                                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 02 1911                                                                                                 |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                      |                                  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br>7b IF UNDER 24 HRS<br>HOURS MIN.                                                        |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                                          | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                      | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.                         |                                  |                                                                                                                              |
| 10 CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                                                                      | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MD |                                                                                                                                                 | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                               | 12b KIND OF BUSINESS OR INDUSTRY |                                                                                                                              |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD                                                                                                                                                                                                                                                                                                          | 13b COUNTY                                                                                                              | 13c CITY OR TOWN<br>BALTO.                                                                                                                      | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>CENTURY N. H.<br>102 N. WACA ST. 21204                  |                                  |                                                                                                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Cook                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                         | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mamie Goldie                                                                                    |                                                                                     |                                                                               |                                  |                                                                                                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                               |                                                                                                                         | 16b SOCIAL SECURITY NO.                                                                                                                         |                                                                                     | 17 INFORMANT<br>ADDRESS<br>CENTURY N. H.                                      |                                  |                                                                                                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>CHF, METABOLIC ACIDOSIS |                                                                                                                         |                                                                                                                                                 |                                                                                     |                                                                               |                                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                                     | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |                                                                                                                         | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                       |                                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                  |                                                                                                                              |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                |                                                                                                                         | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |                                                                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                  |                                                                                                                              |
| 22a I certify that (I) (this hospital) attended the deceased from 6/11/79 to 6/11/79, that (I) (we) last saw the deceased alive on 6/11/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                    |                                                                                                                         |                                                                                                                                                 |                                                                                     |                                                                               |                                  |                                                                                                                              |
| 22b SIGNATURE<br>STEVEN H. RESNICK                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                         | DEGREE<br>MD                                                                                                                                    |                                                                                     | 22c DATE SIGNED<br>6/18/79                                                    |                                  | 22d ADDRESS<br>UNIV. OF MD HOSP                                                                                              |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         | 23b DATE<br>6/23/79                                                                                                                             |                                                                                     | 23c NAME OF CEMETERY OR CREMATORY<br>Md. Nat. Mem. Pk.                        |                                  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel, Md.                                                                     |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                         | ADDRESS<br>1101 E. North Ave.                                                                                                                   |                                                                                     | 25a DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                   |                                  | 25b REGISTRAR'S SIGNATURE<br>Patrick McBrady                                                                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARION M. STANKA</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                             |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR <b>6-30-79</b>                                              |                                                                                   | 2b. HOUR <b>4:30 PM</b>                                    |
| 3 SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                              | 4 RACE <b>WHITE</b>                                                                                                         | 5 DATE OF BIRTH MONTH DAY YEAR <b>JUNE 18, 1882</b>                                                                                                        |                                                                                              | 6 AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS                                      | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY MD</b>                         |                                                            |
| 10 CITY OR TOWN OF DEATH <b>BALTO.</b>                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ARDLEIGH N.H.</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>               | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>                                  |                                                            |
| 13a. STATE <b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                       | 13b. COUNTY                                                                                                                 | 13c. CITY OR TOWN <b>BALTO.</b>                                                                                                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <b>3211 CHESTERFIELD AVE.</b>                                 |                                                            |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                             | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>                                                                                                   |                                                                                              |                                                                                   |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                             | 16b. SOCIAL SECURITY NO. <b>220-22-3791</b>                                                                                                                |                                                                                              | 17 INFORMANT ADDRESS <b>HAROLD PASTER 3211 CHESTERFIELD AVE. 21213</b>            |                                                            |
| 18 CAUSE OF DEATH Enter: only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic cerebro-vascular</b><br><b>4370</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>several yrs</b> |                                                                                                                             |                                                                                                                                                            |                                                                                              |                                                                                   |                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Brain Syndrome</b> <b>several yrs</b>                                                                                                                                                                                                                       |                                                                                                                             |                                                                                                                                                            |                                                                                              |                                                                                   |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |                                                                                                                             |                                                                                                                                                            |                                                                                              |                                                                                   |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |                                                                                                                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                                                     |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    |                                                                                                                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                        |                                                                                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 19 72</b> to <b>June 30 19 79</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>June 30 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                      |                                                                                                                             |                                                                                                                                                            |                                                                                              |                                                                                   |                                                            |
| 22b. SIGNATURE <b>E. Ellsworth Cook</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                             | DEGREE <b>MD</b>                                                                                                                                           |                                                                                              | 22c. DATE SIGNED <b>7-2-79</b>                                                    |                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Ellsworth Cook</b>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             | 22e. ADDRESS <b>2431 Md. Ave. Balt. MD 21218</b>                                                                                                           |                                                                                              |                                                                                   |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                     | 23b. DATE <b>7-3-79</b>                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem.</b>                                                                                                    |                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CO MD</b>                        |                                                            |
| 24 FUNERAL DIRECTOR NAME <b>THOMAS SKARDA F.A.</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                             | 24b. ADDRESS <b>2829 HUDSON ST.</b>                                                                                                                        |                                                                                              | 25a. DATE REC'D. BY REGISTRAR <b>JUL 5 1979</b>                                   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>              |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
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REGISTRAR

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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EVA ELIZABETH STAUDENMAIER</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 11, 1979</b>                        |                                                                                | 2b. HOUR<br><b>7:35A.M.</b>                                                                                                |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>WHITE</b>                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JANUARY 7, 1898</b>                                                                                                |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ST. MARY'S CO., MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>             |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JEWISH CONVALESCENT HOME</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SEAMSTRESS</b>                         |                                                                                                                            |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              |                                                                                                                                                             | 13b. COUNTY<br><b>-----</b>                                                        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? BARNES</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                    |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-01-9893</b>                                                                               |                                                                                    | 17. INFORMANT<br>ADDRESS<br><b>6915 BANK ST.<br/>BALTO., 21224, MD.</b>        |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7373</b> <i>Bronchopneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Senile dementia and kyphoscoliosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>4th.</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i> |                                                                                                                                              |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (h) (this hospital) attended the deceased from <b>12-27-</b> 19 <b>72</b> , to <b>6-11-79</b> 19 <b>79</b> , that (i) (we) last saw the deceased alive on <b>5-15-</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (j) (we) (did) (did not) view the body after death.                                                                                                               |                                                                                                                                              |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><i>Inday</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | DEGREE                                                                                                                                                      |                                                                                    | 22c. DATE SIGNED<br><b>6-12-79</b>                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSE ARDAIZ</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 22e. ADDRESS<br><b>7838 EASTERN BLVD. EASTPOINT, 21224, MD.</b>                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 23b. DATE<br><b>6-14-79</b>                                                                                                                                 |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEMETERY</b>             |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>7401 GERMAN HILL RD. BA. CO., MD.</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><b>JUN 18 1979</b> <i>Barney McReady</i>                                                        |                                                                                    |                                                                                |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Sales &amp; Son, Inc.</i>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                              | 901 S. CONKLING ST.<br>BALTO., 21224, MD.                                                                                                                   |                                                                                    |                                                                                |                                                                                                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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14644  
REG. NO.

|                                                                             |  |                  |  |                                                                                                                                 |  |                                                 |  |                                                                                                                                                             |  |                                                                               |  |                                                        |  |                                                   |  |                                                                                                 |  |  |  |                                                |  |  |  |
|-----------------------------------------------------------------------------|--|------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------------------------|--|---------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                         |  | FIRST<br>John    |  | MIDDLE<br>Staugas                                                                                                               |  | LAST<br>Staugas                                 |  | 2a. DATE KNOWN OF DEATH                                                                                                                                     |  | MONTH<br>6                                                                    |  | DAY<br>7                                               |  | YEAR<br>1979                                      |  | 2b. HOUR<br>M                                                                                   |  |  |  |                                                |  |  |  |
| 3. SEX<br>male                                                              |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5-9-1891                                                                                  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>88 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 7 1979 |  | 2d. HOUR<br>1:36 P                                |  | M                                                                                               |  |  |  |                                                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Lithuania                      |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |  |                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City |  |                                                   |  | MD                                                                                              |  |  |  |                                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1327 Herkimer St. |  |                                                 |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Boiler Maker |  |                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B & O. R. R. |  |                                                                                                 |  |  |  |                                                |  |  |  |
| 13a. STATE<br>Ind.                                                          |  |                  |  |                                                                                                                                 |  |                                                 |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  |                                                                               |  |                                                        |  |                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br>1327 Herkimer St. 21223 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ben Staugas                       |  |                  |  |                                                                                                                                 |  |                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine ?                                                                                                |  |                                                                               |  |                                                        |  |                                                   |  |                                                                                                 |  |  |  |                                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO |  |                  |  | 16b. SOCIAL SECURITY NO.<br>-                                                                                                   |  |                                                 |  | 17. INFORMANT<br>Gellie Staugas                                                                                                                             |  |                                                                               |  | ADDRESS<br>1327 Herkimer St. 21223                     |  |                                                   |  |                                                                                                 |  |  |  |                                                |  |  |  |

4292 IMMEDIATE CAUSE (a) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF \_\_\_\_\_  
 (b) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF \_\_\_\_\_  
 (c) \_\_\_\_\_

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

|                                                                                                                           |  |                                                                |  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK              |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Virginia L. Dolan MD TITLE (SPECIFY) Assistant DATE SIGNED 6-8-79  
EXAMINER'S NAME Virginia L. Dolan, M.D. ADDRESS 111 Penn St.  
(TYPE OR PRINT)

|                                              |                                         |                                    |                               |        |       |
|----------------------------------------------|-----------------------------------------|------------------------------------|-------------------------------|--------|-------|
| 23b. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE                               | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION<br>CITY OR TOWN | COUNTY | STATE |
| burial                                       | 6-11-1979                               | Holy Rescemer                      | Baltimore                     |        | Ind.  |
| 24. FUNERAL DIRECTOR<br>NAME                 | ADDRESS                                 | 25a. DATE REC'D. BY REGISTRAR      | 25b. REGISTRAR'S SIGNATURE    |        |       |
| John J. Cowan & Son, Inc.                    | Balt. Md. 21223<br>No. 901, Hollins St. | JUN 12 1979                        | [Signature]                   |        |       |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

Item #2a Film G532 6/4/79 rc

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14645

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                               |                                                                                                                                                                       |                                                                                            |                                                                                                 |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alta P. Stevens</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                               |                                                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 1, 1979</b>                                 |                                                                                                 | 2b. HOUR<br><b>1:35A M</b>                                                                                                 |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>White</b>                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 27, 1884</b>                                                                                                            |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                                                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Practical Nurse</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medicine</b>                                                                       |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                               | 13b. COUNTY                                                                                                                                                           | 13c. CITY OR TOWN<br><b>Balto.</b>                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Grimes</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie V. Hardy</b>                                                                                                |                                                                                            |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>215-34-5422</b>                                                                                                                        |                                                                                            | 17. INFORMANT ADDRESS<br><b>O. Ellsworth Stevens Balto., Md.</b>                                |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Bronchial Pneumonia</b><br><b>485-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                     |                                                                                                                                               |                                                                                                                                                                       |                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes</b>                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                       |                                                                                            |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                      |                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                            |                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                |                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 30</b> , 19 <b>79</b> , to <b>June 1</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) not view the body after death. |                                                                                                                                               |                                                                                                                                                                       |                                                                                            |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>G. Posner, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                               | 22c. DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                            |                                                                                                 | 22d. DATE SIGNED<br><b>6-1-79</b>                                                                                          |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. POSNER, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                               | 22f. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                                  |                                                                                            |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | 23b. DATE<br><b>6-4-79</b>                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County, Md.</b>                                                    |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               |                                                                                                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1979</b>                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                                                                      |
| 24. ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                       |                                                                                            |                                                                                                 |                                                                                                                            |



14042

1-324

March 1979

Steven

112

Baltimore City

X

USA

105

Practical Training

Harland General Hospital

Baltimore

Dr. W. H. H. H. H.

X

112

105

Barry

112

112

105

112-1-105

112-1-105

112-1-105

105

112

Acute Bronchial Pneumonia

112

112

112

112

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112-1-105

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112



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14646

|                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                              |  | 2a. DATE KNOWN OF DEATH                                                                                                                                                                                                                                                                             |  | MONTH DAY YEAR                                                                                                                                                                                                                                                                                      |  | 2b. HOUR                                                                                                                                                                                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                    |  | 3. SEX                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                                                                                                                                                                                                             |  | 5. DATE OF BIRTH                                                                                                                                                                                                                                                                                    |  |
| Harry W. Stewart                                                                                                                                                                                                                                                                                                                    |  | Male                                                                                                                                                                                                                                                                                                |  | White                                                                                                                                                                                                                                                                                               |  | 12/ 27/1929 49 YRS.                                                                                                                                                                                                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                                |  |
| Virginia                                                                                                                                                                                                                                                                                                                            |  | U.S.A.                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                     |  | Baltimore City, MD.                                                                                                                                                                                                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                   |  |
| Baltimore                                                                                                                                                                                                                                                                                                                           |  | 646 Washington Blvd.                                                                                                                                                                                                                                                                                |  | N/A                                                                                                                                                                                                                                                                                                 |  | N/A                                                                                                                                                                                                                                                                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                                                                                                                                                                                                                         |  | 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                   |  | 13d. STREET ADDRESS                                                                                                                                                                                                                                                                                 |  |
| Maryland                                                                                                                                                                                                                                                                                                                            |  | - - -                                                                                                                                                                                                                                                                                               |  | Baltimore                                                                                                                                                                                                                                                                                           |  | 646 Washington Blvd.                                                                                                                                                                                                                                                                                |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                  |  | 17. INFORMANT                                                                                                                                                                                                                                                                                       |  |
| Harry L. Stewart                                                                                                                                                                                                                                                                                                                    |  | Virgie Ziegler                                                                                                                                                                                                                                                                                      |  | Yes                                                                                                                                                                                                                                                                                                 |  | Mrs. Virgie Stewart                                                                                                                                                                                                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> |  | 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                                                                                                                   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                      |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                                                                                                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                                                                                                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)                                                                                                                                                                                                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                 |  | 22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22c. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22d. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                           |  | 23b. DATE                                                                                                                                                                                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                             |  |
| Burial                                                                                                                                                                                                                                                                                                                              |  | 6/14/1979                                                                                                                                                                                                                                                                                           |  | Grassy Creek Baptist                                                                                                                                                                                                                                                                                |  | Henry County, Va.                                                                                                                                                                                                                                                                                   |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                          |  | 25c. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                          |  |
| E. Barnes                                                                                                                                                                                                                                                                                                                           |  | JUN 15 1979                                                                                                                                                                                                                                                                                         |  | Fleming Funeral Service Benson, Md.                                                                                                                                                                                                                                                                 |  | Fleming Funeral Service Benson, Md.                                                                                                                                                                                                                                                                 |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 4 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                   |                                                                                                                                                             |                                                                                                                                            |                                                                    |                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William McKinley Stiffler                                                                                                                                                                                                                                                                                                 |                                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-20-79                                                                                            |                                                                    | 2b. HOUR<br>3:15 P.M.                                   |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                    | 4 RACE<br>White                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09-14-1900                                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                                                                                   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |                                                                    |                                                         |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>501 E. Barney Street |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Butcher shop                  |                                                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                | 13b. COUNTY                                                                                                                       | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            | 13e. STREET ADDRESS<br>501 E. Barney Street                        |                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bejamin --- Stiffler                                                                                                                                                                                                                                                                                                   |                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Spicer Stiffler                                                                                   |                                                                                                                                            |                                                                    |                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                       | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>218-07-8934                                                             | 17. INFORMANT<br>ADDRESS<br>Wife, Mrs. Elizebeth Stiffler: same address                                                                                     |                                                                                                                                            |                                                                    |                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                   |                                                                                                                                                             |                                                                                                                                            |                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                                                                                                                                                                                                                              |                                                                                                                                   |                                                                                                                                                             |                                                                                                                                            |                                                                    |                                                         |
| 19a. DATE OF OPERATION<br>1976                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>same                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                                    |                                                         |
| 21a. ACCIDENT WAS <input checked="" type="checkbox"/> KILLING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                            |                                                                    |                                                         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                            |                                                                    |                                                         |
| 22. I certify that (I) (the hospital) attended the deceased from <u>May 3, 1979</u> to <u>June 20, 1979</u> , that (I) (we) last saw the deceased alive on <u>May 3, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |                                                                                                                                   |                                                                                                                                                             |                                                                                                                                            |                                                                    |                                                         |
| 22a. SIGNATURE<br><i>C. C. Chiu</i>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                   | DEGREE<br>M.D.                                                                                                                                              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>06-21-79                                       |                                                         |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. C. Chiu, M.D.                                                                                                                                                                                                                                                                                                        |                                                                                                                                   | 22d. ADDRESS<br>1 E. Randall Street, Baltimore, Md. 21230                                                                                                   |                                                                                                                                            |                                                                    |                                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                              | 23b. DATE<br>June 25, 1979                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Maryland                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                       |                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.                                                                                                                                                                                                                                                                                |                                                                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McHenry</i>                                                                                                          |                                                                                                                                            |                                                                    |                                                         |

1. 2. 3. 4. 5. 6. 7.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

3

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14648

|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sarah C Stine                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 13 79                         |                                                                                                                                                             |                                                        | 2b. HOUR<br>8:10am                                                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>White                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 2 1888                                                                                                              |                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Corporation |                                                                        |                                                                                                                                                             |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>Baltimore                                                                                                             |                                                                        | 13c. CITY OR TOWN<br>Woodlawn                                                                                                                               |                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>3101 D. Wood Ford Place                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ralaigh Downman Carter                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Elizabeth Jett   |                                                                                                                                                             |                                                        |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-80-4317 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>James M. Stine Auburn, Pa. |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                                        |                                                                                                                                                             |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                        |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                        |                                                                                                 |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9-8-77</u> 19 <u>79</u> , to <u>6-13-79</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6-13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.          |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                        |                                                                                                 |  |
| 22b. SIGNATURE<br>A.F. Nazemi M-2                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                        | 22c. DATE SIGNED<br>6/13/79                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.F. Nazemi                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                        | 22e. ADDRESS<br>Church Hospital 100 N. Broadway 21231                                                                                                       |                                                        |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>6-14-79                                                                                                                 |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process                                                                                                      |                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br>JUN 14 1979                                                                                                                |                                                        | 25b. REGISTRAR'S SIGNATURE<br>History McBrady                                                   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

STOKES DELORES  
05 31 74  
REG. NO. 14649

|                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                      |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                   |  |
| DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                               |                                                                                                        | DATE                                                                                                                                                     |                                                                     | HOUR                       |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                           |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | HOURS MIN                  |  |
| DELORES YVONNE                                                                                                                                                                                                                                                                                                              |                                                                                                        | 6 17 79                                                                                                                                                  |                                                                     | 11:40 PM                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR         |  |
| Female                                                                                                                                                                                                                                                                                                                      | NEGRO                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 45 YRS.                                                             | MONTHS DAYS HOURS MIN      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                            |  |
| N.C.                                                                                                                                                                                                                                                                                                                        | U.S.A.                                                                                                 |                                                                                                                                                          | Baltimore City MD.                                                  |                            |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                            |  |
| Baltimore                                                                                                                                                                                                                                                                                                                   | Johns Hopkins Hospital                                                                                 | Teacher                                                                                                                                                  | School                                                              |                            |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 14. INSIDE CITY LIMITS?                                             | 15. STREET ADDRESS         |  |
| MD.                                                                                                                                                                                                                                                                                                                         |                                                                                                        | Balto.                                                                                                                                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 522 Sanford Place          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                               | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                             |                                                                     |                            |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                           | FIRST MIDDLE LAST                                                                                      | 17. INFORMANT ADDRESS                                                                                                                                    |                                                                     |                            |  |
| FRANK                                                                                                                                                                                                                                                                                                                       | Hicks                                                                                                  | Mrs. Sadie Givens 522 Sanford Place                                                                                                                      |                                                                     |                            |  |
| 18. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                     |                                                                                                        | 19. DATE OF OPERATION                                                                                                                                    |                                                                     |                            |  |
| ?                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 8/5/79                                                                                                                                                   |                                                                     |                            |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____                                                                                                |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |                                                                     |                            |  |
| 486- Respiratory Arrest                                                                                                                                                                                                                                                                                                     |                                                                                                        | 2 days                                                                                                                                                   |                                                                     |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/p renal transplant, on immunosuppressives                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     |                            |  |
| 21a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 22a. AUTOPSY?                                                                                                                                            | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                            |  |
| 8/5/79                                                                                                                                                                                                                                                                                                                      | chronic renal failure                                                                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          | 23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                     |                            |  |
|                                                                                                                                                                                                                                                                                                                             | P.M. 19                                                                                                |                                                                                                                                                          |                                                                     |                            |  |
| 24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                    | 24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 24c. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |                            |  |
| 25a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                            |  |
| 26a. SIGNATURE                                                                                                                                                                                                                                                                                                              |                                                                                                        | DEGREE                                                                                                                                                   | 26b. DATE SIGNED                                                    |                            |  |
| William P. Blase                                                                                                                                                                                                                                                                                                            |                                                                                                        | MD                                                                                                                                                       | 6/17/79                                                             |                            |  |
| 26c. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |                                                                                                        | 26d. ADDRESS                                                                                                                                             |                                                                     |                            |  |
| William P. Blase                                                                                                                                                                                                                                                                                                            |                                                                                                        | Johns Hopkins Hospital                                                                                                                                   |                                                                     |                            |  |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   | 27b. DATE                                                                                              | 27c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 27d. LOCATION CITY OR TOWN COUNTY STATE                             |                            |  |
| Entombment                                                                                                                                                                                                                                                                                                                  | 6-22-79                                                                                                | Arbutus Memorial Park                                                                                                                                    | Baltimore MD                                                        |                            |  |
| 28a. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                  |                                                                                                        | 28b. ADDRESS                                                                                                                                             | 29a. DATE REC'D. BY REGISTRAR                                       | 29b. REGISTRAR'S SIGNATURE |  |
| Randolph J. Collick                                                                                                                                                                                                                                                                                                         |                                                                                                        | 24316 Oliver St.                                                                                                                                         | JUN 19 1979                                                         | Ruthy McBrady              |  |

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 5 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        |                                                                                                 |                                                                   |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Hydie M Stokes</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 6 79</b>                                 |                                                                                                                                                             |                                                        | 2b. HOUR<br><b>12<sup>05</sup> AM</b>                                                           |                                                                   |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>Black</b>                                                                                                                   |                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 26 67</b>                                                                                                        |                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>11</b> YRS.                                               |                                                                   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>11 00 00</b>                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |                                                                   |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BCRC, University Hosp</b> |                                                                                      |                                                                                                                                                             |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>              |                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Assoc. School</b>                                                                  |  |
| 13a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>Balt</b>                                                                                                                |                                                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                   | 13e. STREET ADDRESS<br><b>2127 W. Mulberry St</b>                                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles White</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ernestine Stokes</b>                                                                                    |                                                        |                                                                                                 |                                                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>                                                                    |                                                                                      | 17. INFORMANT<br><b>Old Chart</b>                                                                                                                           |                                                        | ADDRESS                                                                                         |                                                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b>                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        |                                                                                                 |                                                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>24 hrs</b>                                                           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Septic Shock</b>                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        |                                                                                                 |                                                                   | <b>24 hours</b>                                                                                                            |  |
| (c) <b>Acute Lymphocytic Leukemia</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        |                                                                                                 |                                                                   | <b>2 years</b>                                                                                                             |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Hemorrhage</b>                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        |                                                                                                 |                                                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>6/5/79</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute Peritoneal Dialysis</b> |                                                                                                                                                             |                                                        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                          |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |                                                                                                                                                             |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |                                                                                                                                                             |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                   |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>77</b> , to <b>June</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>June 6</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        |                                                                                                 |                                                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Janice P. Dutcher MD</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        | DEGREE<br><b>MD</b>                                                                             |                                                                   | 22c. DATE SIGNED<br><b>6/6/79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Janice P. Dutcher MD</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        | 22e. ADDRESS<br><b>BCRC, University Hospital</b>                                                |                                                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 23b. DATE<br><b>6/9/79</b>                                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MA AUSTIN</b> |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall P. Lange</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |                                                                                      |                                                                                                                                                             |                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1979</b>                                              |                                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John H. Brady</b>                                                                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                       |  |                                                                                                                                                              |                                                                                                |                                                                                           |                                     |                                                                                                                           |  | REG. NO. 7 9 1 4 6 5 1 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>George Michael Strickroth                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                       |  |                                                                                                                                                              | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 17, 1979                                              |                                                                                           |                                     | 2b. HOUR<br>2:40A M                                                                                                       |  |                        |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br>Caucasian                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 27 1916                                                                                                              |                                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                                |                                     | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                             |  |                        |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                 |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                    |                                     |                                                                                                                           |  |                        |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>The Johns Hopkins Hospital |  |                                                                                                                                                              |                                                                                                | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)<br>Electronic Rependix Avia. |                                     | 15. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                        |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE 16b. COUNTY 16c. CITY OR TOWN<br>Delaware Sussex Rehoboth                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                       |  |                                                                                                                                                              | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                           | 18. STREET ADDRESS<br>7 Bay Rd Ext. |                                                                                                                           |  |                        |  |
| 19. FATHER'S NAME FIRST MIDDLE LAST<br>John Strickroth                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                       |  | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown                                                                                                        |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WWII                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                       |  | 22. SOCIAL SECURITY NO.<br>213-05-5553                                                                                                                       |                                                                                                | 23. INFORMANT ADDRESS<br>ALLEN                                                            |                                     |                                                                                                                           |  |                        |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>396-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Organ System Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiogenic shock after Cardiac Surgery</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 min</u><br><u>2 weeks</u><br><u>2 weeks</u> |  |                                                                                       |  |                                                                                                                                                              |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                       |  |                                                                                                                                                              |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| 25. DATE OF OPERATION<br>5/31/79                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>AORTIC AND MITRAL VALVE DISEASE    |  |                                                                                                                                                              |                                                                                                | 27. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |                                     | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                            |  | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| 32. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |  | 34. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| 35. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> 19 <u>79</u> , to <u>6/17</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/17</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                                                                                                                                                            |  |                                                                                       |  |                                                                                                                                                              |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| 36. SIGNATURE<br>Karl J. Karlson, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                       |  | 37. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |                                                                                                | 38. DATE SIGNED<br>6/17/79                                                                |                                     |                                                                                                                           |  |                        |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KARL J. KARLSON, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                       |  | 40. ADDRESS<br>JOHNS HOPKINS HOSPITAL                                                                                                                        |                                                                                                |                                                                                           |                                     |                                                                                                                           |  |                        |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 42. DATE<br>6/20/79                                                                   |  | 43. NAME OF CEMETERY OR CREMATORY<br>Epworth Methodist                                                                                                       |                                                                                                | 44. LOCATION CITY OR TOWN COUNTY STATE<br>Rehoboth Sussex Del.                            |                                     |                                                                                                                           |  |                        |  |
| 45. FUNERAL DIRECTOR NAME<br>Robert Barranco Ritchie Hiway,                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                       |  | 46. ADDRESS<br>Severena Park                                                                                                                                 |                                                                                                | 47. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                                               |                                     | 48. REGISTRAR'S SIGNATURE<br>Ritchie Hiway                                                                                |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14652

|                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES C. STRONG Jr</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-18-79</b>                  |                                                                                                                                                            | 2b HOUR<br><b>12:20 PM</b> |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>White</b>                                                                                                             |                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 9, 1927</b>                                                                                                  |                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                                                                           |                                                                      | IF UNDER 24 HRS<br>HOURS MIN<br><b>MIN</b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          |                                                                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |                                                                                                                        |                                                                      |                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                       |                                                                                                                                                            |                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>             |  |                                                                                                                        | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>                  |                                            |  |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b COUNTY<br><b>Balto.</b>                                                                                                        |                                                                       | 13c CITY OR TOWN<br><b>Joppa</b>                                                                                                                           |                            | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>300 Oakway</b>                                                                                |                                                                      |                                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles C. Strong Sr.</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ruth Combs</b>                                                                                     |                            |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                             |  | 16b SOCIAL SECURITY NO.<br><b>WW II 414-34-6773</b>                                                                                |                                                                       | 17 INFORMANT<br><b>Hamlett-Dobson Funeral Home, Tenn.</b>                                                                                                  |                            |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                            | 20a AUTO-OP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      |                                            |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                          |  |                                                                                                                                    | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                            | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                                                                        |                                                                      |                                            |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                            | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                        |                                                                      |                                            |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/18</b> 19 <b>79</b> , to <b>6/18</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                             |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            |                                                                                                |  |                                                                                                                        |                                                                      |                                            |  |
| 22b SIGNATURE<br><b>Juan Aguirre</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            | DEGREE<br><b>MD</b>                                                                            |  | 22c DATE SIGNED<br><b>6/18/79</b>                                                                                      |                                                                      |                                            |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Juan Aguirre, MD</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            | 22e ADDRESS<br><b>Sinai Hospital</b>                                                           |  |                                                                                                                        |                                                                      |                                            |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    | 23b DATE<br><b>6-21-79</b>                                            |                                                                                                                                                            |                            | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>                                  |  |                                                                                                                        | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Kingsport, Tenn.</b> |                                            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br><b>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                                                       |                                                                                                                                                            |                            | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                             |  |                                                                                                                        | 25b REGISTRAR'S SIGNATURE<br><b>Robert K. ...</b>                    |                                            |  |

BP

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g541 3/11/80 Items 21a thru 22a STATE OF MARYLAND

FOR  
1 - dad  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 5 3

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                 |                                                                     |                                                                                         |                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>STERLING EDWARD STULTZ</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 27 79</b>               |                                                                                         | 2b. HOUR<br><b>5:20 PM</b> |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>WHITE</b>                                                                                                                                          |                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 21 07</b>                                   |                            |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>                                                                                                                                                                                                                                                                                                                             |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                                                                                                                 |                                                                     | 8. IF UNDER 24 HRS<br>HOURS MIN<br><b>YRS</b>                                           |                            |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                            |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                   |                                                                     | 10. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                      |                            |  |
| 11. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                           |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b>      |                                                                     | 13. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>farmer</b>        |                            |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                            |  | 14b. COUNTY<br><b>Carroll</b>                                                                                                                                   |                                                                     | 14c. CITY OR TOWN<br><b>Westminster</b>                                                 |                            |  |
| 15. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 16. STREET ADDRESS<br><b>730 Littleton Pike</b>                                                                                                                 |                                                                     | 17. KIND OF BUSINESS OR INDUSTRY<br><b>agriculture</b>                                  |                            |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis A. Stultz</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                 | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosie Fogle</b> |                                                                                         |                            |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                       |  | 21. SOCIAL SECURITY NO.<br><b>WW II 215 14 0052</b>                                                                                                             |                                                                     | 22. INFORMANT<br>ADDRESS<br><b>VAMC CLINICAL RECORDS Balto., Md. 21218</b>              |                            |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Laryngeal obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                                                 |                                                                     |                                                                                         |                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>End stage CHF 2° to calcific Aortic Stenosis</b>                                                                                                                                                                            |  |                                                                                                                                                                 |                                                                     |                                                                                         |                            |  |
| 24. DATE OF OPERATION<br><b>9/11/79</b>                                                                                                                                                                                                                                                                                                                                 |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aspirated dinner</b>                                                                                      |                                                                     | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |                            |  |
| 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                               |  | 28. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                                                                     |                                                                                         |                            |  |
| 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 19</b>                                                                                                                                                                                                                                                                                                      |  | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Aspirated dinner</b>                                                        |                                                                     |                                                                                         |                            |  |
| 31. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                  |  | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Hospital - LRVH</b>                                                                 |                                                                     | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                   |                            |  |
| 34. I certify that (I) (this hospital) attended the deceased from <b>JUNE 20, 1979</b> to <b>JUNE 27, 1979</b> , that (I) (we) last saw the deceased alive on <b>JUNE 27, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                 |  |                                                                                                                                                                 |                                                                     |                                                                                         |                            |  |
| 35. SIGNATURE<br><b>R. Phillips</b>                                                                                                                                                                                                                                                                                                                                     |  | 36. DEGREE<br><b>MD</b>                                                                                                                                         |                                                                     | 37. DATE SIGNED<br><b>4/21/79</b>                                                       |                            |  |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. PHILLIPS</b>                                                                                                                                                                                                                                                                                                              |  | 39. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>                                                                                                   |                                                                     |                                                                                         |                            |  |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |  | 41. DATE<br><b>7/1/79</b>                                                                                                                                       |                                                                     | 42. NAME OF CEMETERY OR CREMATORY<br><b>Sams Creek Cemetery New Windsor Carroll Md.</b> |                            |  |
| 43. FUNERAL DIRECTOR<br>NAME<br><b>D. D. Zatzler</b>                                                                                                                                                                                                                                                                                                                    |  | 44. ADDRESS<br><b>New Windsor, Md.</b>                                                                                                                          |                                                                     | 45. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                       |                            |  |
| 46. REGISTRAR'S SIGNATURE<br><b>D. D. Zatzler</b>                                                                                                                                                                                                                                                                                                                       |  | 47. REGISTRAR'S SIGNATURE<br><b>D. D. Zatzler</b>                                                                                                               |                                                                     |                                                                                         |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14654

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |                                                                                    |                                                                                                                                                            |                                                                               |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Bettie L. Suber</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-13-79</b>                               |                                                                                                                                                            |                                                                               | 2b HOUR<br><b>8 P M</b>                                                                                                                              |                                                                                                |                                                                                                                           |                                                    |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>Black</b>                                                                                                                      |                                                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 4 15</b>                                                                                                         |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS                                                                                                      |                                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                           |                                                    |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                                                                      |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |                                                                                    | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                                                                                               |                                                                                                |                                                                                                                           |                                                    |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles Gen. Hosp.</b> |                                                                                    |                                                                                                                                                            |                                                                               | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                      |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                    |  |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 13b COUNTY<br><b>Balto.</b>                                                        |                                                                                                                                                            | 13c CITY OR TOWN<br><b>Balto.</b>                                             |                                                                                                                                                      | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                           | 13e STREET ADDRESS<br><b>398 20 1/2 Street</b>     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Bowers</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lottie Mae Coon</b>             |                                                                                                                                                            |                                                                               |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             | 16b SOCIAL SECURITY NO.<br><b>220-05-9272</b>                                      |                                                                                                                                                            | 17 INFORMANT<br><b>Sam Suber</b>                                              |                                                                                                                                                      | ADDRESS<br><b>308 20 1/2 Street</b>                                                            |                                                                                                                           |                                                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Candidiomyces anast</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Carcinoma of the breast w/ metastases 9 mos.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                             |                                                                                    |                                                                                                                                                            |                                                                               |                                                                                                                                                      |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CVA w/ Right Hemiparesis</b>                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                                    |                                                                                                                                                            |                                                                               |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
| 19a DATE OF OPERATION<br><b>9/14/78</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of left breast</b> |                                                                                                                                                            |                                                                               | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  |                                                                                                | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                    |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 P.M. 19 79</b>             |                                                                                                                                                            | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |                                                                                                                                                            | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/11/79</b> to <b>6/13/79</b> , that (I) (we) lost saw the deceased alive on <b>6/13/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                              |  |                                                                                                                                             |                                                                                    |                                                                                                                                                            |                                                                               |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
| 22b SIGNATURE<br><b>Maureen P. Valler, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |                                                                                    |                                                                                                                                                            |                                                                               | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                | 22c DATE SIGNED<br><b>6/13/79</b>                                                                                         |                                                    |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maureen P. Valler</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             | 22e ADDRESS<br><b>North Charles General</b>                                        |                                                                                                                                                            |                                                                               |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                    |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             | 23b DATE<br><b>6/17/79</b>                                                         |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br><b>Piny Grove Ch Cem.</b>                |                                                                                                                                                      | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Columbia, S.C.</b>                             |                                                                                                                           |                                                    |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                                                    |                                                                                                                                                            | ADDRESS<br><b>1101 E. North Ave.</b>                                          |                                                                                                                                                      | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                                             |                                                                                                                           | 25b REGISTRAR'S SIGNATURE<br><b>Henry H. Bandy</b> |  |

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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

7 9 1 4 6 5 5

REG. NO.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                       |                                                                                                        | 2a. DATE OF DEATH                                                   |                                                                                                                                                          | 2b. HOUR                                                                       |                                                                |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                             |                                                                                                        | 2a. DATE OF DEATH                                                   |                                                                                                                                                          | 2b. HOUR                                                                       |                                                                |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                            |                                                                                                        | MONTH DAY YEAR                                                      |                                                                                                                                                          | HOUR                                                                           |                                                                |
| Anna SULEWSKI                                                                                                                                                                                                                                                                                                |                                                                                                        | 6 24 79                                                             |                                                                                                                                                          | 8 a.m.                                                                         |                                                                |
| 3. SEX                                                                                                                                                                                                                                                                                                       | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                          | 7. IF UNDER 1 YEAR                                                             |                                                                |
| F                                                                                                                                                                                                                                                                                                            | WHITE                                                                                                  | MONTH DAY YEAR                                                      | 90                                                                                                                                                       | MONTHS DAYS HOURS MIN                                                          |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                    |                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                |
| POLAND                                                                                                                                                                                                                                                                                                       |                                                                                                        | U.S.A.                                                              |                                                                                                                                                          | BALTIMORE CITY MD.                                                             |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                                |
| BALTIMORE                                                                                                                                                                                                                                                                                                    | South Baltimore Gen. Hosp.                                                                             |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| 13a. STATE                                                                                                                                                                                                                                                                                                   | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS                                                            |                                                                |
| MD                                                                                                                                                                                                                                                                                                           |                                                                                                        | Baltimore                                                           |                                                                                                                                                          | 2024 E. PRATT ST.                                                              |                                                                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                            |                                                                                                                                                          |                                                                                |                                                                |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                            |                                                                                                        | FIRST MIDDLE LAST                                                   |                                                                                                                                                          |                                                                                |                                                                |
| GREGORY GONGLE                                                                                                                                                                                                                                                                                               |                                                                                                        | MARION ZLOTOWSKI                                                    |                                                                                                                                                          |                                                                                |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                            | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT                                                       | ADDRESS                                                                                                                                                  |                                                                                |                                                                |
| NO                                                                                                                                                                                                                                                                                                           | 218-32-354                                                                                             | BERNARD SULEWSKI                                                    | 1817 THAMES ST.                                                                                                                                          |                                                                                |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                        |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) Pulmonary edema - Bronchopneumonia                                                                                                                                                                                                                                                       |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| 410- DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                               |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| (b) Acute Myocardial infarction                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| (c) Generalized arteriosclerosis                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                           |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          | 20a. AUTOPSY?                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        | P.M. 19                                                             |                                                                                                                                                          |                                                                                |                                                                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                       |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 05-05 1979 to 6-24 1979, that (I) (we) last saw the deceased alive on 6-24 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |                                                                                                        | DEGREE                                                              |                                                                                                                                                          | 22c. DATE SIGNED                                                               |                                                                |
| R. AREM                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                     |                                                                                                                                                          | 06-24-79                                                                       |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                        |                                                                                                        | 22e. ADDRESS                                                        |                                                                                                                                                          |                                                                                |                                                                |
| R. AREM                                                                                                                                                                                                                                                                                                      |                                                                                                        | South Baltimore General Hosp.                                       |                                                                                                                                                          |                                                                                |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                    | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |                                                                                |                                                                |
| BURIAL                                                                                                                                                                                                                                                                                                       | 6-27-79                                                                                                | HOLY ROSARY                                                         | BALTO. MD.                                                                                                                                               |                                                                                |                                                                |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                    |                                                                                                        | ADDRESS                                                             | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                                                     |                                                                |
| JOHN M. WEBER & SONS                                                                                                                                                                                                                                                                                         |                                                                                                        | 401 S. CHESTER                                                      | JUN 26 1979                                                                                                                                              | Ruthy McCreedy                                                                 |                                                                |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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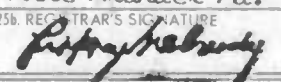
CONCEAL

GEORGE

212 32 32W BERNARD SUDEWICKI THAME

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #18a-22a Film G538 7/2/79 STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                 |  |                        |  |                                                                                                                                             |  |                                                                                                              |  |                                                                                                                                                             |  | REG. NO. 14656                                                                                              |  |                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Marie D. Sullenger</b>                                                                                                                                                                                                                                                                                                                                                      |  |                        |  |                                                                                                                                             |  |                                                                                                              |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 10 1979</b> |  | 2b. HOUR<br>M<br><b>1:10P</b><br>M |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 28, 1938 41</b>                                                                               |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>41</b>                                                         |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                       |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 10 1979</b>                                              |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |  |                                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                          |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>705 E. Patapsco Avenue</b> |  |                                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tavern</b>                                                          |  |                                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                        |  | 13b. COUNTY<br><b>---</b>                                                                                                                   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>705 E. Patapsco Avenue 21225</b>                                                  |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernie Leemaster</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                        |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel Berrand</b>                                        |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                      |  |                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-32-4738</b>                                                               |  | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md. 21225</b><br><b>Mr. Michael Sullenger 705 E. Patapsco Ave.</b> |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>410-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                |  |                        |  |                                                                                                                                             |  |                                                                                                              |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                |  |                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                     |  |                        |  |                                                                                                                                             |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                           |  |                                                                                                              |  |                                                                                                                                                             |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |                                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                     |  |                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                             |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                            |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                        |  |                                                                                                                                             |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                 |  |                        |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>                                                                                                      |  |                                                                                                              |  | DATE SIGNED<br><b>6/11/79</b>                                                                                                                               |  |                                                                                                             |  |                                    |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                        |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>                                                                                                  |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                                             |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                        |  | 23b. DATE<br><b>6/14/79</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Anne Arundel Md.</b>                                                                             |  |                                                                                                             |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mc Cully's Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                        |  |                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                                                          |  | 25b. REGISTRAR'S SIGNATURE<br>                                         |  |                                                                                                             |  |                                    |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                |                                                                                    |                                                                                                 |                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD SUSSMAN</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 4, 1979</b>                                                                                                                     |                                                                                    | 2b. HOUR<br><b>7:10 P.M.</b>                                                                    |                                                                                    |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>WHITE</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 6, 1907</b>                                                                                                                      |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b><br>YRS. MONTHS DAYS HOURS MIN.                     |                                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8. MARRIAGE STATUS<br>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.                        |                                                                                    |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MANAGER</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>                                   |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 13b. COUNTY<br><b>BALTO.</b>                                                                                                                                                   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACOB SUSSMAN</b>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PEARL UNKNOWN</b>                                                                                                          |                                                                                    |                                                                                                 |                                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>346-01-1526</b>                                                                                                                                 |                                                                                    | 17. INFORMANT ADDRESS<br><b>MRS. ANNETTE SUSSMAN</b><br><b>2916 MARNAT RD., APT. A #21209</b>   |                                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4/149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                                |                                                                                                                                                                                |                                                                                    |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 minutes</b><br><b>4 yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic Renal Failure</b>                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                                                |                                                                                    |                                                                                                 |                                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                               |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                                    |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                            |                                                                                                                                                |                                                                                                                                                                                |                                                                                    |                                                                                                 |                                                                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                              |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                    |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                         |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/27</b> , 19 <b>79</b> , to <b>6/4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |                                                                                                                                                |                                                                                                                                                                                |                                                                                    |                                                                                                 |                                                                                    |
| 22b. SIGNATURE<br><b>Stephen A. Wank</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | DEGREE<br><b>Attending Physician</b>                                                                                                                                           |                                                                                    | 22c. DATE SIGNED<br><b>6/4/79</b>                                                               |                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen A. Wank</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 22e. ADDRESS<br><b>601 N. Broadway, Baltimore, Md</b>                                                                                                                          |                                                                                    |                                                                                                 |                                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                | 23b. DATE<br><b>JUNE 6, 1979</b>                                                                                                                                               |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL</b>                                        |                                                                                    |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                |                                                                                    |                                                                                                 |                                                                                    |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                             |                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Robert Helms</b>                                               |                                                                                    |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 should be retained by the hospital or attending physician.

1 2 3 4 1 2 3 4





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 7/77  
(VRA 15 (4))TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                        |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | 2a. DATE OF DEATH                                              |  | MONTH DAY YEAR                               |  | 2b. HOUR |  |
| ANNA                                                                                                                                                                                                                                                                                                       |  | MARGARET                                                                                                  |  | SVOBODA                                                                                                                                                     |  | SVOBODA                                                             |  | 6- 21-79                                                       |  | 8:15pm                                       |  |          |  |
| 3 SEX                                                                                                                                                                                                                                                                                                      |  | 4 RACE                                                                                                    |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS                              |  |          |  |
| Female                                                                                                                                                                                                                                                                                                     |  | Caucasian                                                                                                 |  | July 5, 1906                                                                                                                                                |  | 72                                                                  |  | MONTHS DAYS                                                    |  | HOURS MIN.                                   |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |                                              |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                   |  | U.S.A.                                                                                                    |  |                                                                                                                                                             |  | Baltimore City,                                                     |  |                                                                |  |                                              |  | MD       |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                                |  |                                              |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                                  |  | Church Hospital Corp.                                                                                     |  | Homemaker                                                                                                                                                   |  | Home                                                                |  |                                                                |  |                                              |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                            |  |                                              |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                   |  | -                                                                                                         |  | Baltimore                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 114 S. Collington Avenue                                       |  |                                              |  | 21231    |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                                                  |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| Edward Sweeting                                                                                                                                                                                                                                                                                            |  | Elizabeth Baier                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |  |                                                                |  |                                              |  |          |  |
| No                                                                                                                                                                                                                                                                                                         |  | 212-01-2346                                                                                               |  | Marie Wingate (dgtr)                                                                                                                                        |  | 803 N. Kenwood Avenue                                               |  |                                                                |  |                                              |  | 21205    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| IMMEDIATE CAUSE (a) SEPTIC SHOCK                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 586- DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| (b) RENAL FAILURE                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| (c)                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |          |  |
|                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                              |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                     |  |                                                                |  |                                              |  |          |  |
|                                                                                                                                                                                                                                                                                                            |  | P.M. 19                                                                                                   |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                               |  | CITY OR TOWN                                                        |  | COUNTY                                                         |  | STATE                                        |  |          |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 22a. I certify that (1) this hospital attended the deceased from 6-7 19 79, to 6-21 19 79, that (1) we last saw the deceased alive on 6-21 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED                                                    |  |                                                                |  |                                              |  |          |  |
| WALKER                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  | 6/21/79                                                             |  |                                                                |  |                                              |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                              |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| DR. WALKER IMPAGLIATELLI                                                                                                                                                                                                                                                                                   |  | 100N. broadway baltimore, maryland                                                                        |  | 31                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                               |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                       |  | CITY OR TOWN                                                   |  | COUNTY                                       |  | STATE    |  |
| Burial                                                                                                                                                                                                                                                                                                     |  | 6/25/79                                                                                                   |  | St. Stanislaus Cem.                                                                                                                                         |  | Baltimore, Md.                                                      |  |                                                                |  |                                              |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                       |  | 24b. ADDRESS                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                                                |  |                                              |  |          |  |
| Schamunek Funeral Home, Inc.                                                                                                                                                                                                                                                                               |  | 3321 Brehms Lane Balto. Md. 21213                                                                         |  | JUN 26 1979                                                                                                                                                 |  | P. J. Kelly                                                         |  |                                                                |  |                                              |  |          |  |

CHINESE

3



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

 BP  
 DHMH - 17  
 (VR A13 ME (5))  
 15M 7/76

 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                             |  |                                                                                                                                              |                                                                        |                                                                                                 |  |                                                                                                                                                             |  | REG. NO. 14659                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Otto G. Sword</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                             |  |                                                                                                                                              |                                                                        |                                                                                                 |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 10 1979</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 31 10 68</b>                                                                                        |                                                                        | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>68 YRS</b>                          |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6 10 1979</b>                                                                                                 |  | 7b. HOUR<br><b>7:15 P</b>                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |                                                                        |                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |                                                                        |                                                                                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>A+P FOOD</b>                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>                                                         |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                         |  |                             |  |                                                                                                                                              |                                                                        |                                                                                                 |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>BALTO</b> |  | 13c. CITY OR TOWN<br><b>ESSEX</b>                                                                                                            |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>354 TOWNSEND RD</b>                                                                                                               |  |                                                                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GARFIELD C. SWORD</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                             |  |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSALIE PALMER</b> |                                                                                                 |  |                                                                                                                                                             |  |                                                                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                             |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>                                                                                                         |                                                                        | 17. INFORMANT ADDRESS<br><b>ROBERT E. SWORD.</b>                                                |  |                                                                                                                                                             |  |                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured intracranial aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                |  |                             |  |                                                                                                                                              |                                                                        |                                                                                                 |  |                                                                                                                                                             |  |                                                                                                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                |  |                             |  |                                                                                                                                              |                                                                        |                                                                                                 |  |                                                                                                                                                             |  |                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                            |                                                                        |                                                                                                 |  |                                                                                                                                                             |  | 20. HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                             |  |                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                            |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |                                                                                                                                                             |  |                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                       |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                  |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                                             |  |                                                                                                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                             |  |                                                                                                                                              |                                                                        |                                                                                                 |  |                                                                                                                                                             |  |                                                                                                          |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                             |  | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                          |                                                                        |                                                                                                 |  | DATE SIGNED<br><b>6/11/79</b>                                                                                                                               |  |                                                                                                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                             |  | ADDRESS<br><b>111 PennSt</b>                                                                                                                 |                                                                        |                                                                                                 |  | BALTO., MD.                                                                                                                                                 |  |                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>6/14/79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLENCOE</b>                                                                                         |                                                                        |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ESSEX BALTO MD.</b>                                                                                        |  |                                                                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CONNELLY F.H. 300 MACE AVE.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                             |  |                                                                                                                                              |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dickie McCreedy</b>                                                                                                        |  |                                                                                                          |  |

1 4 0 3 2



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #18a-22a Film G533 7/30/79                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | STATE OF MARYLAND Items 18a, 18b, 18c Film G534 8-21-79                                                                                      |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| FOR 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                      |  |  |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | REG. NO. 14660                                                                                                                               |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LAWRENCE</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>23</b> YEAR <b>1979</b>                                    |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>5:02</b>                                                                                                                         |  |  |  |  |  |  |  |  |  |
| 4. RACE <b>black</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>6 23 19 79</b>                                                                                                   |  |  |  |  |  |  |  |  |  |
| 5. DATE OF BIRTH MONTH <b>2</b> DAY <b>5</b> YEAR <b>56</b>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>23</b> YRS.                                                                                               |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                      |  |  |  |  |  |  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                                                               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>130 N. Asquith Street Apt 8-C</b> |  |  |  |  |  |  |  |  |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                            |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 13b. COUNTY <b>Balto.</b>                                                                                                                    |  |  |  |  |  |  |  |  |  |
| 13c. CITY OR TOWN <b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                 |  |  |  |  |  |  |  |  |  |
| 13e. STREET ADDRESS <b>130 N. Aisquith St.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Clarence</b> MIDDLE <b>Sye</b> LAST <b>Sye</b>                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Callene</b> MIDDLE <b>Washington</b> LAST <b>Washington</b>                                                |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>220-64-5171</b>                                                                                                  |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT <b>Freda Sye</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | ADDRESS <b>130 N. Aisquith St.</b>                                                                                                           |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: <b>3049</b> IMMEDIATE CAUSE (a) <b>Multiple Drug Intoxication</b> <del>Methadone poisoning</del>                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                 |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                            |  |  |  |  |  |  |  |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                                       |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                  |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b> M.D. <b>Assistant</b> MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>6/23/79</b>                                                                                                                   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | ADDRESS <b>111 Penn Street</b>                                                                                                               |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 23b. DATE <b>6/29/79</b>                                                                                                                     |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE                                                                                |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | ADDRESS <b>1101 E. North Ave.</b>                                                                                                            |  |  |  |  |  |  |  |  |  |
| 25a. DATE OF BY REGISTRATION <b>JUN 27 1979</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 25b. BY REGISTRATION <b>John A. Brady</b>                                                                                                    |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                             |  |                                                                                                                                                             |                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <i>Willie</i> MIDDLE <i>Tanner</i> LAST                                                                                                                                                                                                                                                                                                  |                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>6 9 79</i>                           |  | 2b. HOUR <i>3:45</i> AM                                                                                                                                     |                                                                                 |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><i>Black</i> | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>5/15/28</i>                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>51</i>                                                                                                                |                                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>                                                                                                                                                                                                                                                                                                                          |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore, City</i>                                                                                                                                                                                                                                                                                                                        |                         | 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Balto. City</i>                                 |                                                                                 |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                      |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                           |  | 12c. STREET ADDRESS<br><i>916 E. 20th St.</i>                                                                                                               |                                                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Md.</i>                                                                                                                                                                                                                                                                            |                         | 13b. COUNTY<br><i>Balto.</i>                                                |  | 13c. CITY OR TOWN<br><i>Balto.</i>                                                                                                                          |                                                                                 |
| 14. FATHER'S NAME<br>FIRST <i>Rosvelt</i> LAST <i>Tanner</i>                                                                                                                                                                                                                                                                                                                          |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Pinkie</i> MIDDLE <i>Whitlock</i> LAST |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                            |                                                                                 |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                               |                         | 18. INFORMANT<br><i>Ida Tanner</i>                                          |  | 19. ADDRESS<br><i>916 E. 20th St.</i>                                                                                                                       |                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br><i>5-85-</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Chronic renal failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                         |                                                                             |  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 mth.</i><br><i>1 year.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>pancreatic insufficiency, Alcohol abuse</i>                                                                                                                                                                                                |                         |                                                                             |  |                                                                                                                                                             |                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                             |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-8</i> 19 <i>79</i> to <i>6-9</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6-8</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |                         |                                                                             |  |                                                                                                                                                             |                                                                                 |
| 22b. SIGNATURE<br><i>Daniel Feirtos</i>                                                                                                                                                                                                                                                                                                                                               |                         | DEGREE<br><i>MD</i>                                                         |  | 22c. DATE SIGNED<br><i>6-9-79</i>                                                                                                                           |                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Daniel Feirtos</i>                                                                                                                                                                                                                                                                                                                        |                         | 22e. ADDRESS<br><i>Baltimore City Hospital</i>                              |  |                                                                                                                                                             |                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                         |                         | 23b. DATE<br><i>6/13/79</i>                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cem.</i>                                                                                               |                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Brooklyn, Md.</i>                                                                                                                                                                                                                                                                                                                    |                         | 23e. DATE REC'D. BY REGISTRAR                                               |  | 23f. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                            |                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles A. Rice</i>                                                                                                                                                                                                                                                                                                                                |                         | ADDRESS<br><i>1300 Eutaw Pl</i>                                             |  | 25. DATE REC'D. BY REGISTRAR<br><i>JUN 12 1979</i>                                                                                                          |                                                                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by letter.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Eddeman</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 5, 1979</b>             |                                                                                       |                                                                                                 | 2b. HOUR<br><b>11:03 AM</b>                                                                                                                          |                                                                 |                                                                                                                            |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>Cau.</b>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 12 12</b>                                                                                                        |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS                                      |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>66</b>                                                                                                          |                                                                 | IF UNDER 24 HRS<br>HOURS MIN.<br><b>11:03</b>                                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Vir.</b>                                                                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                     |                                                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |                                                                                                                                                             |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Martin Co.</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                                                                                                  |                                                                 |                                                                                                                            |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    |                                                                                                                                                             | 13b. COUNTY<br><b>-</b>                                                | 13c. CITY OR TOWN<br><b>Balto.</b>                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>436 Torner Rd. 21221</b>                                                                                                   |                                                                 |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gordon Tarr</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Thornton</b> |                                                                                       |                                                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>230-15-1109</b>                         |                                                                                       | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Audrey Tarr 436 Torner Rd.</b>                              |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Anterior myocardial infarction</b><br><b>3979</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>BACTERIAL ENDOCARDITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RHEUMATIC VALVULAR DISEASE</b> |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 |                                                                                                                                                      |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>&gt; 4 days</b><br><b>710 years</b>                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>LAENNEC'S CIRRHOSIS w/ PORTAL HYPERTENSION</b>                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                       |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> , 19 <b>79</b> , to <b>6/5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/5/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                      |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Jerome Snyder</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                 | 22c. DATE SIGNED<br><b>6/5/79</b>                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. SNYDER</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 | 22e. ADDRESS<br><b>MERCY HOSP. BALTO. MD.</b>                                                                                                        |                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             | 23b. DATE<br><b>6-8-79</b>                                             |                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crem.</b>                                  |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc. 6415 Belair Rd.</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    |                                                                                                                                                             |                                                                        |                                                                                       |                                                                                                 | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                                                                                                    |                                                                 |                                                                                                                            |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                      |                                           |                                                                                                                                                             |                             |                                                                                                                    |  |                                                                                  |  | REG. NO. 14663                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                      |                                           |                                                                                                                                                             |                             |                                                                                                                    |  |                                                                                  |  |                                                                                                          |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Andrew Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                      |                                           |                                                                                                                                                             |                             |                                                                                                                    |  |                                                                                  |  | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1979<br>6 7 19 79 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 1 77                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>2 | IF UNDER 1 YR. MONTHS DAYS                                                                                                                                  | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>6 7 19 79                                                                              |  | 2d. HOUR<br>8:20 P.M.                                                            |  |                                                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                                                  |  |                                                                                  |  |                                                                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |                                           |                                                                                                                                                             |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |                                                                                                          |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 13b. COUNTY                                                                                                                          |                                           | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  | 13e. STREET ADDRESS<br><b>1130 Stockton St.</b>                                  |  |                                                                                                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Andre Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                      |                                           | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rachel Winchester</b>                                                                                      |                             |                                                                                                                    |  |                                                                                  |  |                                                                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                      |                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                             | 17. INFORMANT ADDRESS<br><b>Rachel Winchester 1130 Stockton St.</b>                                                |  |                                                                                  |  |                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Drowning</b><br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. |                         |                                                                                                                                      |                                           |                                                                                                                                                             |                             |                                                                                                                    |  |                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                      |                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                             |                                                                                                                    |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                      |                                           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11:30 6 7 19 79</b>                                                                                      |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject drowned in bathtub</b> |  |                                                                                  |  |                                                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                      |                                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                                                                                  |                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1130 Stockton St., Baltimore Md.</b>                          |  |                                                                                  |  |                                                                                                          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                                                            |                         |                                                                                                                                      |                                           |                                                                                                                                                             |                             |                                                                                                                    |  |                                                                                  |  |                                                                                                          |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                      |                                           | TITLE (SPECIFY) <b>Assistant</b>                                                                                                                            |                             | MEDICAL EXAMINER                                                                                                   |  | DATE SIGNED <b>6/8/79</b>                                                        |  |                                                                                                          |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                      |                                           | ADDRESS <b>111 Penn Street</b>                                                                                                                              |                             |                                                                                                                    |  |                                                                                  |  |                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 23b. DATE<br><b>6/12/79</b>                                                                                                          |                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                                                                                               |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. Md.</b>                                             |  |                                                                                  |  |                                                                                                          |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                      |                                           | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                        |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                |  |                                                                                  |  |                                                                                                          |  |

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STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14664

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                            |                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Clarence Jack Taylor</i>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 3 79</i>                                 |                                                                                      | 2b. HOUR<br><i>2:18A</i>                                                                                                   |                                                      |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><i>White</i>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 16 99</i>                                                                                                        |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i>                                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.                                                                          |                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington</i>                                                                                                                                                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |                                                                                                                            |                                                      |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Printer</i>   |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Printing</i> |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                                                                                                        | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>2205 Eastern Avenue</i>                                    |                                                                                                                            |                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>                                                                                             |                                                                                      |                                                                                      |                                                                                                                            |                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                    | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                                      | 17. INFORMANT ADDRESS<br><i>William Colgan 434 S. Gilman St.</i>                     |                                                                                                                            |                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i><br>1579 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Severe malnutrition</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastatic Carcinoma of Pancreas</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 minutes</i><br><i>4 months</i> |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                            |                                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                            |                                                      |
| 19a. DATE OF OPERATION<br><i>4/3/79</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Wt. loss, Abdominal mass</i>                                                                         |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |                                                      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |                                                      |
| 22a. I certify that (if this hospital attended the deceased from <i>March 25, 1979</i> to <i>June 3, 1979</i> , that I saw the deceased alive on <i>June 3, 1979</i> , and that in my opinion death occurred on the date and hour and from the causes stated above, and that I did not view the body after death.                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                                            |                                                      |
| 22b. SIGNATURE<br><i>Adam Billet MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                             |                                                                                      | DEGREE                                                                               |                                                                                                                            | 22c. DATE SIGNED<br><i>6/3/79</i>                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Adam Billet</i>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             |                                                                                      | 22e. ADDRESS<br><i>Mercy Hospital, Balta Md.</i>                                     |                                                                                                                            |                                                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                    | 23b. DATE<br><i>June 5, 1979</i>                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Mem. Pk.</i>                       |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Catonsville Balta Md.</i>                                                 |                                                      |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Ambrose Funeral Home, Inc. 1328 Sulphur Spr. Rd.</i>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 5 1979</i>                                   |                                                                                                                            |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Esther Hahn</i>                                     |                                                                                                                            |                                                      |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

14064



14064



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CRAIG E. TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 07 79</b>                  |                                                                                                                                                                                              |  | 2b. HOUR<br><b>8:10 P.M.</b>                                                                    |  |                                                                                                                            |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>WHITE</b>                                                                                                                 |                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 10 04</b>                                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75 YRS.</b>                                                |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0</b>                                                                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                                         | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                                 |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>124 E. LAKE AVENUE</b> |                                                                         |                                                                                                                                                                                              |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PUBLIC RELATIONS</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMP.</b>                                                                      |  |
| 13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b COUNTY                                                                                                                             |                                                                         | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>124 E. LAKE AVENUE, 21212</b>                                                                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DOROTHY PEISSNER</b> |                                                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-03-2851</b>                                                           |                                                                         | 17 INFORMANT ADDRESS<br><b>ELIZABETH C. TAYLOR, 124 E. LAKE AVENUE</b>                                                                                                                       |  |                                                                                                 |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Possible acute myocardial infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arterio-sclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>11 years</b> |  |                                                                                                                                        |                                                                         |                                                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                         |                                                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                                         |                                                                                                                                                                                              |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |                                                                         | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                     |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                                         | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>Dec 22</b> 19 <b>77</b> to <b>March 30</b> 19 <b>79</b> , that (1) (we) lost<br>saw the deceased alive on <b>March 30</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) did (did not) view the body after death.                                                                                         |  |                                                                                                                                        |                                                                         |                                                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 22b SIGNATURE<br><b>Nelson C. Sun</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                         | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |                                                                                                 |  | 22c DATE SIGNED<br><b>8 June 79</b>                                                                                        |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NELSON C. SUN, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                                         | 22e ADDRESS<br><b>MERCY HOSPITAL, BALTIMORE, MARYLAND</b>                                                                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b DATE<br><b>06-08-79</b>                                                                                                            |                                                                         | 23c NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS</b>                                                                                                                                 |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                     |  |                                                                                                                            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.,</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                         | ADDRESS<br><b>21229 4107 WILKENS AVE.</b>                                                                                                                                                    |  | 25a DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>                                                 |  |                                                                                                                            |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

COOPER

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 4 6 6 6

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                            |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                     |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gertrude E. Turner Taylor</b>                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                            | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>6 22 19 79</b> |                                                                                                                                                             |                                                                                    | 2b. HOUR<br>M<br><b>11:20 A</b>                                                                 |                                                                                     |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 1, 1945</b>                                                                                  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>34 YRS.</b>                        | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     | IF UNDER 24 HRS.                                                                   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 22 19 79</b>                                 | 24 HOUR<br><b>11:20 A</b>                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                        |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                            |                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Md.</b>                              |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3200 Edmondson Avenue</b> |                                                                             |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |                                              |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                            |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 13b. COUNTY                                                                                                                                |                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Turner</b>                                                                                                                                                                                                                                                                                                                                                                           |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Odums</b>                                                                      |                                                                             | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy Odums 3940 Edmondson Ave.</b>                                                                                      |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                                                    |                         | 16b. SOCIAL SECURITY NO.<br><b>217-40-3655</b>                                                                                             |                                                                             | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy Odums 3940 Edmondson Ave.</b>                                                                                      |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9571 Multiple visceral and skeletal injuries</b><br>IMMEDIATE CAUSE (a) <b>Multiple visceral and skeletal injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                    |                         |                                                                                                                                            |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                            |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                          |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                      |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6/22/79</b>                                                                          |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>jumped from bridge</b>                                                  |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street-bridge</b>                                                        |                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3200 Edmondson Ave. Baltimore Md.</b>                                                               |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                                                            |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                     |                                              |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                        |                                                                             | MEDICAL EXAMINER                                                                                                                                            |                                                                                    | DATE SIGNED <b>6/22/79</b>                                                                      |                                                                                     |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | ADDRESS<br><b>111 Penn Street</b>                                                                                                          |                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                          |                         | 23b. DATE<br><b>6/27/79</b>                                                                                                                |                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>                                                                                             |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Maryland</b>                     |                                                                                     |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEROY O. DYETT &amp; SON 4600 Liberty Hgts. Avenue</b>                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                            |                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                         |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                            |                                                                                     |                                              |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |                                                                |                                                                                |                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Marion E. Taylor                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 30, 1979           |                                                                                | 2b. HOUR<br>6:45 A.M.       |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>Black                                                                                                             |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 2 21                                   |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58<br>YRS. MONTHS DAYS HOURS MIN.           |                             |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hosp. |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                             |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              | 13b. COUNTY<br>Balto.                                          |                                                                                | 13c. CITY OR TOWN<br>Balto. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry T. Perkins                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Amby |                                                                                |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>214-24-1815                                                                                      |                                                                | 17. INFORMANT<br>Jennie Rollings                                               |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma to Brain and other organs<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                 |                                                                |                                                                                |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                        |  |                                                                                                                              |                                                                |                                                                                |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                   |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                       |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                             |  |                                                                                                                              |                                                                |                                                                                |                             |  |
| 22b. SIGNATURE<br>Winston Hugh Williams MD                                                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                                       |                                                                | 22c. DATE SIGNED<br>6/30/79                                                    |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Winston Hugh Williams                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br>c/o Provident Hospital                                                                                       |                                                                |                                                                                |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>7/6/79                                                                                                          |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                          |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                                                                                                                                                                                                                                                                |  | 23e. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                                                  |                                                                |                                                                                |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br>1101 E. North Ave.                                                                                                |                                                                | 25. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                     |                             |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>NAOMI C. TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |                              |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 16 1979</b> |                                                                                                           | 2b. HOUR<br><b>10 P.M.</b>                                                                   |                                                                                                                         |                                                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                              |                              | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 12, 1894</b>                                                                                                     |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>84</b>                                                         |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                         |                                                                                              |                                                                                                                         |                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1217 Roundhill Road</b> |                              |                                                                                                                                                             |                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant-Fidelity &amp; Deposit</b> |                                                                                              | 12b. KIND OF BUSINESS INDUSTRY                                                                                          |                                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 13b. COUNTY<br><b>Balto.</b> |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Balto.</b>                      |                                                                                                           | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                         | 13e. STREET ADDRESS<br><b>1217 Roundhill Road</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Benjamin L. Brooks</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |                              | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>May Craig</b>                                                                                              |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>215-10-8570</b>                                                           |                              | 17. INFORMANT ADDRESS<br><b>Mr. Arthur W. Taylor Same</b>                                                                                                   |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA OF BREAST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>11 YEARS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b> |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                              |                                                                                                                                                             |                                                         | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                                                                          |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 71</b> to <b>16 JUNE 19 79</b> , that (I) (we) lost the deceased alive on <b>13 JUNE 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                  |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 22b. SIGNATURE<br><b>J. Dixon Hills M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |                              | 22c. DATE SIGNED<br><b>16 JUN 1979</b>                                                                                                                      |                                                         |                                                                                                           |                                                                                              | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Dixon Hills</b>                                                          |                                                   |  |
| 22e. ADDRESS<br><b>3501 ST. PAUL ST BALTIMORE 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>6-20-79</b>                                                                                                          |                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>                                                                                                       |                                                         | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b>                                   |                                                                                              |                                                                                                                         |                                                   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Henry W. Jenkins</b>                                                     |                                                                                              |                                                                                                                         |                                                   |  |
| 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |                              |                                                                                                                                                             |                                                         |                                                                                                           |                                                                                              |                                                                                                                         |                                                   |  |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14669

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                         |  |                                                                                                                                        |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| FOR<br>1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                        |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Walter Taylor</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                        |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 17 19 79</b> |  | 2b. HOUR<br><b>M</b>                                                                                                                                        |  |                                                                                     |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 17 49</b>                                                                                   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>30 YRS</b>                                                          |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                                  |  | IF UNDER 24 HRS. HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  |                                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1701 N. Brentwood</b> |  |                                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET ADDRESS<br><b>1701 Brentwood Ave.</b>                                                                                                           |  |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ferman Taylor</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                         |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Thompson</b>                                        |  |                                                                                                                                                             |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                     |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-52-6911</b>                                                                                         |  | 17. INFORMANT ADDRESS<br><b>Mary Taylor 3741 Reisterstown Rd.</b>                                            |  |                                                                                                                                                             |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Seizure disorder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |                         |  |                                                                                                                                        |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Chronic Alcoholism</b>                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                        |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                      |  |                                                                                                              |  |                                                                                                                                                             |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                              |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                |  |                                                                                                                                                             |  |                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                            |  |                                                                                                                                                             |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |                                                                                                                                        |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                     |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>                                                                                                                                                                                                                                                                                                                                                                                           |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                    |  |                                                                                                              |  | DATE SIGNED<br><b>6/18/79</b>                                                                                                                               |  |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  | ADDRESS<br><b>111 Penn St. Balto., MD</b>                                                                                              |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                         |  | 23b. DATE<br><b>6/21/79</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Co., Md.</b>                                                                                       |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                        |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO. 79 14670

|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                     |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>BRENDA J. TAYMAN                                                                                                                                                                                                                                                                                                                  |                                                                                                                                     |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>6 3 79                             |                                                                                                | 2b HOUR<br>9:15 PM                                                                                                         |
| 3 SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                         | 4 RACE<br>WHITE                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 25 45                                                                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>33 YRS                                 |                                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA                                                                                                                                                                                                                                                                                                               | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD                      |                                                                                                |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br>UNKNOWN                                                                                |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MARYLAND                                                                                                                                                                                                                                                    |                                                                                                                                     | 13b COUNTY<br>BALTIMORE                                                                                                                                    | 13c CITY OR TOWN<br>BALTIMORE                                            | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>2419 ASHTON STREET, 21223                                                                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE L. KELCH                                                                                                                                                                                                                                                                                                                |                                                                                                                                     | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ZELDA M. PAUGH                                                                                             |                                                                          |                                                                                                |                                                                                                                            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                               | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-44-6505                                                               | 17 INFORMANT ADDRESS<br>ZELDA M. KELCH, 2419 ASHTON STREET, 21223                                                                                          |                                                                          |                                                                                                |                                                                                                                            |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Asperated Pneumonia<br>3481<br>DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxic Brain Damage<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) Comatose |                                                                                                                                     |                                                                                                                                                            |                                                                          |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                     |                                                                                                                                     |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                                            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                          | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |                                                                                                                                     | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                          | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |                                                                                                                                     | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                          | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-1 1977 to 6-1 1979, that (I) (we) last saw the deceased alive on 5-25 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                               |                                                                                                                                     |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>R. Chen-Tan                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                     | DEGREE<br>MD                                                                                                                                               |                                                                          | 22c. DATE SIGNED<br>6-4-79                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. CHEN-TAN                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 22e ADDRESS<br>Baltimore City Hospital                                                                                                                     |                                                                          |                                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                     | 23b. DATE<br>06-07-79                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. OLIVET                                                                                                           |                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                          |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                            |                                                                                                                                     | ADDRESS<br>21229                                                                                                                                           |                                                                          | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                                    | 25b. REGISTRAR'S SIGNATURE<br>Fitzgerald                                                                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14671

|                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                             |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                                                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                   |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                                                                                |  |
| FIRST MIDDLE LAST                                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                        |  | IF UNDER 1 YEAR                                                                                                                                          |  | IF UNDER 24 HRS                                                                                                         |  |
| 3 SEX                                                                                                                                              |  | 4 RACE                                                                                                 |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE                                                                                                                                         |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                |  |
| 17. INFORMANT                                                                                                                                      |  | 18. ADDRESS                                                                                            |  | 19. DATE OF OPERATION                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  | 21d. INJURY OCCURRED                                                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  | 21d. INJURY OCCURRED                                                                                                    |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                |  | 21f. LOCATION                                                                                          |  | 21g. CITY OR TOWN                                                                                                                                        |  | 21h. COUNTY                                                                                                             |  |
| 21i. STATE                                                                                                                                         |  | 21j. DATE                                                                                              |  | 21k. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 21l. LOCATION                                                                                                           |  |
| 21m. CITY OR TOWN                                                                                                                                  |  | 21n. COUNTY                                                                                            |  | 21o. STATE                                                                                                                                               |  | 21p. DATE                                                                                                               |  |
| 21q. NAME                                                                                                                                          |  | 21r. ADDRESS                                                                                           |  | 21s. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 21t. REGISTRAR'S SIGNATURE                                                                                              |  |
| 21u. NAME                                                                                                                                          |  | 21v. ADDRESS                                                                                           |  | 21w. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 21x. REGISTRAR'S SIGNATURE                                                                                              |  |
| 21y. NAME                                                                                                                                          |  | 21z. ADDRESS                                                                                           |  | 21aa. DATE REC'D. BY REGISTRAR                                                                                                                           |  | 21ab. REGISTRAR'S SIGNATURE                                                                                             |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Aspirator pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1/2 hour

436-  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebro Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

pulmonary embolism

|                                                                     |  |                     |  |                                                                                |  |                             |  |
|---------------------------------------------------------------------|--|---------------------|--|--------------------------------------------------------------------------------|--|-----------------------------|--|
| 21a. DATE OF OPERATION                                              |  | 21b. TIME OF INJURY |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  | 21d. INJURY OCCURRED        |  |
| 21a. DATE OF OPERATION                                              |  | 21b. TIME OF INJURY |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  | 21d. INJURY OCCURRED        |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION       |  | 21g. CITY OR TOWN                                                              |  | 21h. COUNTY                 |  |
| 21i. STATE                                                          |  | 21j. DATE           |  | 21k. NAME OF CEMETERY OR CREMATORY                                             |  | 21l. LOCATION               |  |
| 21m. CITY OR TOWN                                                   |  | 21n. COUNTY         |  | 21o. STATE                                                                     |  | 21p. DATE                   |  |
| 21q. NAME                                                           |  | 21r. ADDRESS        |  | 21s. DATE REC'D. BY REGISTRAR                                                  |  | 21t. REGISTRAR'S SIGNATURE  |  |
| 21u. NAME                                                           |  | 21v. ADDRESS        |  | 21w. DATE REC'D. BY REGISTRAR                                                  |  | 21x. REGISTRAR'S SIGNATURE  |  |
| 21y. NAME                                                           |  | 21z. ADDRESS        |  | 21aa. DATE REC'D. BY REGISTRAR                                                 |  | 21ab. REGISTRAR'S SIGNATURE |  |

17041-1-17

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

7 9 1 4 6 7 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                             |                                                       |                                                                                                                                                         |                            |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LILLIAN TERRY</b>                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-28-79</b> |                                                                                                                                                         | 2b. HOUR<br><b>8:45 PM</b> |                                                                                                                            |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br><b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                      |                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 20 09</b>                                                                                                     |                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>69</b>                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ba Ho. Md</b>                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                  |                                                       | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Md.</b>                                                          |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto</b>                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Penn. Ave. Center</b>                                                                                                                                                                                                                               |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bar Maid</b>                                                                     |                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                   |                                                       | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                       |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>W H K</b>                                                                                                                                                                                                                                                                        |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>W H K</b>                                                                                                                                                                                                                                                                                                                |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                        |                            | 16b. SOCIAL SECURITY NO.<br><b>219-10-9834</b>                                                                             |  |
| 17 INFORMANT<br>ADDRESS<br><b>Kimberly Clark, 1918 N. Monroe St.</b>                                                                                                                                                                                                                                                         |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Heart Disease</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                            |                            |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Left hemiplegia - Right above-knee amputation</b>                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                             |                                                       |                                                                                                                                                         |                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                            |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                               |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                  |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                          |                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                      |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                       |                            |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-10-79</b> to <b>6-28-79</b> , that (I) (we) last saw the deceased alive on <b>6-28-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                                                                             |                                                       |                                                                                                                                                         |                            |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>R. D. Crossley</b>                                                                                                                                                                                                                                                                                      |  | DEGREE                                                                                                                                                                                                                                                                                                                                                                      |                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |                            | 22c. DATE SIGNED<br><b>7/3/79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. D. Crossley</b>                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br><b>936 W. North Ave Balto Md</b>                                                                                                                                                                                                                                                                                                                            |                                                       | 23a. BURIAL, CREMATION, REMOVAL                                                                                                                         |                            | 23b. DATE<br><b>7-3-79</b>                                                                                                 |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul</b>                                                                                                                                                                                                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>                                                                                                                                                                                                                                                                                                               |                                                       | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>POWELL F/H 319 N. Seton St</b>                                                                               |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1979</b>                                                                        |  |

2041 45



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 6 7 3

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SAMUEL E TETSO</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 8 79</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>4:15</b> M                                                                                                  |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>W</b>                                                                                                            |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 20 07</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                                                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD, USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                     |                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY</b> |                                                      |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truckdriver</b>                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRANS.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                    |                                                      | 13c. CITY OR TOWN<br><b>BALTO</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>448 FAWCETT ST</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SANTO TETSO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DOMENICA ROMONDA</b>                                                                                    |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>215-05-1341</b>                                                   |                                                      | 17. INFORMANT<br>ADDRESS<br><b>CHART</b>                                                                                                                    |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>887-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PSEUDOMONAS SEPSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>12hrs</b><br><b>9 DAYS</b> |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>FRACTURED HIP ; CIRRHOSIS</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>5/19/79</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FX HIP</b>                                                              |                                                      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> 19 <b>79</b> to <b>6/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/8</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                  |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>E. Ross</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE<br><b>MD</b>                                                                                                            |                                                      | 22c. DATE SIGNED<br><b>6/8/79</b>                                                                                                                           |  | 22d. ADDRESS<br><b>22 S. GREENE BALTO MD</b>                                                                               |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. ROSS MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |                                                      |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>6/12/79</b>                                                                                                    |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home</b> ADDRESS<br><b>3631 Falls Road 21211</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21041 87

RECEIVED 10/10/63



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 7 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                 |                                                                                                                                                             |                                                                               |                                                                                |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MAE N. THIEM                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 5 79                                    |                                                                                | 2b. HOUR<br>6 30 AM                                                                                                        |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>W                                                                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 14 11                                                                                                                  |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS                                      | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS                                                                                                                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>DAVIS & HEMPLE                                                                        |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                 |                                                                                                                                                             | 13b. COUNTY<br>BALTIMORE                                                      | 13c. CITY OR TOWN<br>WYNNEWOOD                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRANCIS X. GAMACHE                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                 |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>OCTAVIA GUNETTE                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>214-22-6182                                                                                                                     |                                                                               | 17. INFORMANT ADDRESS<br>HENRY J. THIEM, 5814 HERON DRIVE, 21227               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Peritonitis (Stoepitococcal)</u><br>5570<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gangrenous Small Bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Mesenteric Venous Thrombosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                 |                                                                                                                                                             |                                                                               |                                                                                |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                                                                             |                                                                               |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                          |                                                                                                                                 |                                                                                                                                                             |                                                                               |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>V. Sukumar                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 | DEGREE<br>MD                                                                                                                                                |                                                                               | 22c. DATE SIGNED<br>6/5/79                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V. SUKUMAR                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                 | 22e. ADDRESS<br>81 Agnes.                                                                                                                                   |                                                                               |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br>06-08-79                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL CEMETERY                                                                                                |                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND             |                                                                                                                            |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 | ADDRESS<br>21229 4107 WILKENS AVE.                                                                                                                          |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                    |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                 |                                                                                                                                                             |                                                                               | 25b. REGISTRAR'S SIGNATURE<br>Rafaela...                                       |                                                                                                                            |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 6 7 5

1- FOR  
STATE  
REGISTRAR

REG NO

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| DECEASED NAME<br>(TYPE OR PRINT)<br>ANN THIMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                    | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>6/17/79                                                                                      |                                                                                                                                                         |  | 2b HOUR<br>9:00 A M                                                                                                                        |                                                      |  |                                                                                                                           |  |  |
| 3 SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>CAUCASIAN                |                                                                                                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 22 1991                                                                                                         |  |                                                                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87                 |  |                                                                                                                           |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA |                                                                                                                                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD |  |                                                                                                                           |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                    | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINDALE GER. CENTER. |                                                                                                                                                         |  | 12a US EMPLOYMENT (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES PERSON                                                                  |                                                      |  | 12b DRESS SHOP                                                                                                            |  |  |
| 13a STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                    | 13b COUNTY<br>BALTIMORE                                                                                                            |                                                                                                                                                         |  | 13c CITY OR TOWN<br>BALTIMORE                                                                                                              |                                                      |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB THIMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                    | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA UNKNOWN                                                                    |                                                                                                                                                         |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                  |                                                      |  | 16b SOCIAL SECURITY NO.<br>218-32-0734                                                                                    |  |  |
| 17a US EMPLOYMENT (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES PERSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                    | 17b DRESS SHOP                                                                                                                     |                                                                                                                                                         |  | 17c ADDRESS<br>3307 GLEN AVE #21215                                                                                                        |                                                      |  | 17d CITY OR TOWN<br>BALTIMORE                                                                                             |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cancer of Ovary c metastases<br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                    |                                                                                                                                    |                                                                                                                                                         |  |                                                                                                                                            |                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 months                                                                  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                    |                                                                                                                                    |                                                                                                                                                         |  |                                                                                                                                            |                                                      |  |                                                                                                                           |  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                    | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |                                                                                                                                                         |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                        |                                                      |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                    | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |                                                                                                                                                         |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                              |                                                      |  |                                                                                                                           |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                    | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |                                                                                                                                                         |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                           |                                                      |  |                                                                                                                           |  |  |
| 22a I certify that (this hospital) attended the deceased from 6/17 1979 4-3 to 6/17 1979, that (we) last saw the deceased alive on 6/17 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) |  |                                    |                                                                                                                                    |                                                                                                                                                         |  |                                                                                                                                            |                                                      |  |                                                                                                                           |  |  |
| 22b SIGNATURE<br>Noel D. LIST M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                    | DEGREE<br>M.D.                                                                                                                     |                                                                                                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                      |  | 22c DATE SIGNED<br>6/17/79                                                                                                |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>NOEL D. LIST M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                    | 22e ADDRESS<br>GREENSBORO BLVD (21215)                                                                                             |                                                                                                                                                         |  |                                                                                                                                            |                                                      |  |                                                                                                                           |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                    | 23b DATE<br>JUNE 18, 1979                                                                                                          |                                                                                                                                                         |  | 23c NAME OF CEMETERY OR CREMATORY<br>MOGAN ABRAHAM                                                                                         |                                                      |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD                                                           |  |  |
| 24 FUNERAL DIRECTOR<br>Sal Leunson Bros                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                    | ADDRESS<br>6010 Resistor Rd.                                                                                                       |                                                                                                                                                         |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                                                                                |                                                      |  | 25b REGISTRAR'S SIGNATURE<br>Anthony McBrady                                                                              |  |  |

01041 11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14676

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             |                                                                               |                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------|
| 1. STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                             | FOR                                                                           |                                         |
| 1. DECEASED NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                             | 2a. DATE KNOWN OF DEATH                                                       |                                         |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                             | MONTH DAY YEAR HOUR                                                           |                                         |
| Doris Thomas                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                             | 6 10 19 79 M                                                                  |                                         |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE                                                     | 5. DATE OF BIRTH                                                              | 6. AGE (IN YEARS)                       |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                  | Black                                                       | 5 5 31                                                                        | 48 YRS                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?                                | 8. MARRIED                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH    |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                    | USA                                                         | NEVER MARRIED                                                                 | Baltimore City, MD.                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 | 12b. KIND OF BUSINESS OR INDUSTRY       |
| Baltimore City                                                                                                                                                                                                                                                                                                                                                                                                                          | Union Memorial Hospital (D.O.A.)                            |                                                                               |                                         |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                              | 13b. COUNTY                                                 | 13c. INSIDE CITY LIMITS?                                                      | 13d. STREET ADDRESS                     |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                     | Balto.                                                      | YES                                                                           | 1633 Abbotston St.                      |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME                                    | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?                                   |                                         |
| Virgil Johnson                                                                                                                                                                                                                                                                                                                                                                                                                          | Lucille Johnson                                             | No                                                                            |                                         |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                           | ADDRESS                                                     |                                                                               |                                         |
| Helen Ferguson                                                                                                                                                                                                                                                                                                                                                                                                                          | 1636 Abbotston St.                                          |                                                                               |                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                               |                                         |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |                                                                               |                                         |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>                                                                                                                                                                                                                                                                                                                                                                      |                                                             |                                                                               |                                         |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                          |                                                             |                                                                               |                                         |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |                                                                               |                                         |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                          |                                                             |                                                                               |                                         |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |                                                                               |                                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                          |                                                             |                                                                               |                                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           | 20. AUTOPSY?                                                                  |                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                         |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         | P.M. 19                                                     |                                                                               |                                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET                                                          | CITY OR TOWN COUNTY STATE               |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                             |                                                                               |                                         |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                             | TITLE (SPECIFY)                                                               | DATE SIGNED                             |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                             | Assistant                                                                     | 6/11/79                                 |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             | ADDRESS                                                                       |                                         |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                             | 111 Penn St. Balto., MD.                                                      |                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                               | 23b. DATE                                                   | 23c. NAME OF CEMETERY OR CREMATORY                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6/14/79                                                     | Mt. Calvary Cem.                                                              | Anne Arundel Co., Md.                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                               | 25a. DATE REC'D. BY REGISTRAR                               |                                                                               | 25b. REGISTRAR'S SIGNATURE              |
| Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                                                          | 1101 E. North Ave.                                          |                                                                               | JUN 15 1979                             |

*Richard A. Crosby*

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                              |  |                                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>James H. Thomas</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 2a. DATE OF DEATH<br>Month <b>08</b> Day <b>08</b> Year <b>79</b>                                            |  | 2b. HOUR<br>M                                                                                                                                                          |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>Black</b>                                                                                      |  | 5. DATE OF BIRTH<br><b>4-28-07</b>                                                                                                                                     |  |
| 6. AGE (In years last birthday)<br><b>71</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                       |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____                                                                   |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                                                                                                                             |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>Baltimore, City</b> Md.                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                              |  |                                                                                                                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>307 E. Lafayette Ave.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Balto.</b>                                                                                 |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  |
| 13d. STREET AND NUMBER<br><b>307 E. Lafayette Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                              |  |                                                                                                                                                                        |  |
| 14. FATHER'S NAME First Middle Last<br><b>James H. Thomas</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Florence Deshield</b>                                       |  |                                                                                                                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-0129</b>                                                               |  | 17. INFORMANT<br><b>Ruth Caldwell</b> Address<br><b>307 E. LaFayette</b>                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of rectum</u><br><b>1541</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u> |  |                                                                                                              |  |                                                                                                                                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                      |  |                                                                                                              |  |                                                                                                                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                              |  |                                                                                                                                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____                        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                                                                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/24</u> , 19 <u>79</u> , to <u>2/13</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                                                      |  |                                                                                                              |  |                                                                                                                                                                        |  |
| 22b. SIGNATURE<br><u>M. M. Urst MD</u> DEGREE _____ ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                     |  |                                                                                                              |  | 22c. DATE SIGNED<br><u>6-10-79</u>                                                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (Type) <u>M. M. URST</u>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                              |  | 22e. ADDRESS<br><u>601 N. BROADWAY, BALT. 21205</u>                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><u>6/12/79</u>                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cem.</u>                                                                                                           |  |
| 23d. LOCATION (City or Town) (County) (State)<br><u>Westport, Md.</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                              |  |                                                                                                                                                                        |  |
| 24. FUNERAL DIRECTOR<br><u>Charles A. Rice 1300 Eutaw Pl.</u>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                              |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JUN 12 1979</u>                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

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|                                                                                                                                                                                                                                                                                                                                                                             |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                 |                                                 |                                                                             |                                               |              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------|--------------|
| 1. DECEASED-NAME<br>(Type or print) <i>Lillian Thomas</i>                                                                                                                                                                                                                                                                                                                   |  |                                           | 2a. DATE OF DEATH<br>6 Month 17 Day 1979 Year                                                                  |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br>5:30 P.M.                                                                                                           |                                                 |                                                                             |                                               |              |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><i>Black</i>                   |                                                                                                                | 5. DATE OF BIRTH<br><i>7-8-98</i>                                                                                                                           |                                                                                                 | 6. AGE (In years last birthday)<br><i>80</i> YRS.                                                                               |                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                    |                                               |              |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i> |                                                                                                                | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. COUNTY OF DEATH<br><i>GARRISON City</i> Md.                                                                                  |                                                 |                                                                             |                                               |              |
| 10. CITY OR TOWN OF DEATH<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                |  |                                           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>GARRISON VAN NURS. CEN.</i> |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Retired</i>                       |                                                 |                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>0</i> |              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MO</i>                                                                                                                                                                                                                                                                  |  |                                           | 13b. COUNTY<br><i>BALTO</i>                                                                                    |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                 | 13e. STREET AND NUMBER<br><i>607 PENN. AVE.</i> |                                                                             |                                               |              |
| 14. FATHER'S NAME First Middle Last<br><i>UNKNOWN</i>                                                                                                                                                                                                                                                                                                                       |  |                                           | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>UNKNOWN</i>                                                   |                                                                                                                                                             |                                                                                                 |                                                                                                                                 |                                                 |                                                                             |                                               |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>UNKNOWN</i>                                                                                                                                                                                                                                                                                        |  |                                           | 16b. SOCIAL SECURITY NO.<br><i>215-22-0536</i>                                                                 |                                                                                                                                                             | 17. INFORMANT Address<br><i>Patient's Chart E. Rudin GUN Center</i>                             |                                                                                                                                 |                                                 |                                                                             |                                               |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>1749</i> IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Breast</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>6 yrs.</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                 |                                                 |                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Diabetes Mellitus, congestive Heart Failure.</i>                                                                                                                                                                                  |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                 |                                                 |                                                                             |                                               |              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  |                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                               |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |                                               |              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                          |  |                                           | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                     |                                                                                                                                                             |                                                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                 |                                                 |                                                                             |                                               |              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                    |  |                                           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |                                                                                                                                                             |                                                                                                 | 21f. LOCATION Street or R.F.D. No.                                                                                              |                                                 | City or Town                                                                |                                               | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-15-1977</i> , to <i>6-17-1979</i> , that (I) (we) last saw the deceased alive on <i>6-17-1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                        |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                 |                                                 |                                                                             |                                               |              |
| 22b. SIGNATURE<br><i>Shaukat Y. Khan</i> MD DEGREE                                                                                                                                                                                                                                                                                                                          |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                 | 22c. DATE SIGNED<br><i>6-17-79</i>                                          |                                               |              |
| 22d. PHYSICIAN'S NAME (Type)<br><i>SHAUKAT Y. KHAN</i>                                                                                                                                                                                                                                                                                                                      |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><i>1105 North Point Blvd. Balt. MD 21227</i>                                                                    |                                                 |                                                                             |                                               |              |
| 23a. BURIAL, CREMATION, or other disposition<br><i>Cremation</i>                                                                                                                                                                                                                                                                                                            |  |                                           | 23b. DATE<br><i>6/23/79</i>                                                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Mem Park</i>                                  |                                                                                                                                 |                                                 | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i> |                                               |              |
| 24. FUNERAL DIRECTOR<br><i>K. Law Funeral Home 4811 Park Heights Ave.</i> ADDRESS                                                                                                                                                                                                                                                                                           |  |                                           |                                                                                                                |                                                                                                                                                             |                                                                                                 | 25a. REC'D BY REGISTRAR<br><i>DATE JUN 22 1979</i>                                                                              |                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Patsy McBratney</i>                        |                                               |              |

19

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Operation

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14679

|                                  |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                                      |  |                           |  |                                                          |  |                                      |  |                                   |  |                         |  |                         |  |                         |  |                          |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                         |  |                     |  |                     |  |                     |  |                     |  |                     |  |           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| 1. STATE REGISTRAR               |  | 2a. DATE KNOWN OF DEATH |  | 2b. DATE KNOWN OF DEATH |  | 2c. DATE KNOWN OF DEATH |  | 2d. DATE KNOWN OF DEATH |  | 2e. DATE KNOWN OF DEATH |  | 2f. DATE KNOWN OF DEATH |  | 2g. DATE KNOWN OF DEATH              |  | 2h. DATE KNOWN OF DEATH   |  | 2i. DATE KNOWN OF DEATH                                  |  | 2j. DATE KNOWN OF DEATH              |  | 2k. DATE KNOWN OF DEATH           |  | 2l. DATE KNOWN OF DEATH |  | 2m. DATE KNOWN OF DEATH |  | 2n. DATE KNOWN OF DEATH |  | 2o. DATE KNOWN OF DEATH  |  | 2p. DATE KNOWN OF DEATH |  | 2q. DATE KNOWN OF DEATH |  | 2r. DATE KNOWN OF DEATH |  | 2s. DATE KNOWN OF DEATH |  | 2t. DATE KNOWN OF DEATH |  | 2u. DATE KNOWN OF DEATH |  | 2v. DATE KNOWN OF DEATH |  | 2w. DATE KNOWN OF DEATH |  | 2x. DATE KNOWN OF DEATH |  | 2y. DATE KNOWN OF DEATH |  | 2z. DATE KNOWN OF DEATH |  |                     |  |                     |  |                     |  |                     |  |                     |  |                     |  |                     |  |                     |  |                     |  |                     |  |                     |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  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| 1. DECEASED NAME (TYPE OR PRINT) |  | 3. SEX                  |  | 4. RACE                 |  | 5. DATE OF BIRTH        |  | 6. AGE (IN YEARS)       |  | 7. DATE OF BIRTH        |  | 8. AGE (IN YEARS)       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. CITY OR TOWN OF DEATH |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  | 13a. STATE              |  | 13b. COUNTY             |  | 13c. CITY OR TOWN       |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS     |  | 13f. STREET ADDRESS     |  | 13g. STREET ADDRESS     |  | 13h. STREET ADDRESS     |  | 13i. STREET ADDRESS     |  | 13j. STREET ADDRESS     |  | 13k. STREET ADDRESS     |  | 13l. STREET ADDRESS     |  | 13m. STREET ADDRESS     |  | 13n. STREET ADDRESS     |  | 13o. STREET ADDRESS     |  | 13p. STREET ADDRESS |  | 13q. STREET ADDRESS |  | 13r. STREET ADDRESS |  | 13s. STREET ADDRESS |  | 13t. STREET ADDRESS |  | 13u. STREET ADDRESS |  | 13v. STREET ADDRESS |  | 13w. STREET ADDRESS |  | 13x. STREET ADDRESS |  | 13y. STREET ADDRESS |  | 13z. STREET ADDRESS |  | 13aa. STREET ADDRESS |  | 13ab. STREET ADDRESS |  | 13ac. STREET ADDRESS |  | 13ad. STREET ADDRESS |  | 13ae. STREET ADDRESS |  | 13af. STREET ADDRESS |  | 13ag. STREET ADDRESS |  | 13ah. STREET ADDRESS |  | 13ai. STREET ADDRESS |  | 13aj. STREET ADDRESS |  | 13ak. STREET ADDRESS |  | 13al. STREET ADDRESS |  | 13am. STREET ADDRESS |  | 13an. STREET ADDRESS |  | 13ao. STREET ADDRESS |  | 13ap. STREET ADDRESS |  | 13aq. STREET ADDRESS |  | 13ar. STREET ADDRESS |  | 13as. STREET ADDRESS |  | 13at. STREET ADDRESS |  | 13au. STREET ADDRESS |  | 13av. STREET ADDRESS |  | 13aw. STREET ADDRESS |  | 13ax. STREET ADDRESS |  | 13ay. STREET ADDRESS |  | 13az. STREET ADDRESS |  | 13ba. STREET ADDRESS |  | 13bb. STREET ADDRESS |  | 13bc. STREET ADDRESS |  | 13bd. STREET ADDRESS |  | 13be. STREET ADDRESS |  | 13bf. STREET ADDRESS |  | 13bg. STREET ADDRESS |  | 13bh. STREET ADDRESS |  | 13bi. STREET ADDRESS |  | 13bj. STREET ADDRESS |  | 13bk. STREET ADDRESS |  | 13bl. STREET ADDRESS |  | 13bm. STREET ADDRESS |  | 13bn. STREET ADDRESS |  | 13bo. STREET ADDRESS |  | 13bp. STREET ADDRESS |  | 13bq. STREET ADDRESS |  | 13br. STREET ADDRESS |  | 13bs. STREET ADDRESS |  | 13bt. STREET ADDRESS |  | 13bu. STREET ADDRESS |  | 13bv. STREET ADDRESS |  | 13bw. STREET ADDRESS |  | 13bx. STREET ADDRESS |  | 13by. STREET ADDRESS |  | 13bz. STREET ADDRESS |  | 13ca. STREET ADDRESS |  | 13cb. STREET ADDRESS |  | 13cc. STREET ADDRESS |  | 13cd. STREET ADDRESS |  | 13ce. STREET ADDRESS |  | 13cf. STREET ADDRESS |  | 13cg. STREET ADDRESS |  | 13ch. STREET ADDRESS |  | 13ci. STREET ADDRESS |  | 13cj. STREET ADDRESS |  | 13ck. STREET ADDRESS |  | 13cl. STREET ADDRESS |  | 13cm. STREET ADDRESS |  | 13cn. STREET ADDRESS |  | 13co. STREET ADDRESS |  | 13cp. STREET ADDRESS |  | 13cq. STREET ADDRESS |  | 13cr. STREET ADDRESS |  | 13cs. STREET ADDRESS |  | 13ct. STREET ADDRESS |  | 13cu. STREET ADDRESS |  | 13cv. STREET ADDRESS |  | 13cw. STREET ADDRESS |  | 13cx. STREET ADDRESS |  | 13cy. STREET ADDRESS |  | 13cz. STREET ADDRESS |  | 13da. STREET ADDRESS |  | 13db. STREET ADDRESS |  | 13dc. STREET ADDRESS |  | 13dd. STREET ADDRESS |  | 13de. STREET ADDRESS |  | 13df. STREET ADDRESS |  | 13dg. STREET ADDRESS |  | 13dh. STREET ADDRESS |  | 13di. STREET ADDRESS |  | 13dj. STREET ADDRESS |  | 13dk. STREET ADDRESS |  | 13dl. STREET ADDRESS |  | 13dm. STREET ADDRESS |  | 13dn. STREET ADDRESS |  | 13do. STREET ADDRESS |  | 13dp. STREET ADDRESS |  | 13dq. STREET ADDRESS |  | 13dr. STREET ADDRESS |  | 13ds. STREET ADDRESS |  | 13dt. STREET ADDRESS |  | 13du. STREET ADDRESS |  | 13dv. STREET ADDRESS |  | 13dw. STREET ADDRESS |  | 13dx. STREET ADDRESS |  | 13dy. STREET ADDRESS |  | 13dz. STREET ADDRESS |  | 13ea. STREET ADDRESS |  | 13eb. STREET ADDRESS |  | 13ec. STREET ADDRESS |  | 13ed. STREET ADDRESS |  | 13ee. STREET ADDRESS |  | 13ef. STREET ADDRESS |  | 13eg. STREET ADDRESS |  | 13eh. STREET ADDRESS |  | 13ei. STREET ADDRESS |  | 13ej. STREET ADDRESS |  | 13ek. STREET ADDRESS |  | 13el. STREET ADDRESS |  | 13em. STREET ADDRESS |  | 13en. STREET ADDRESS |  | 13eo. STREET ADDRESS |  | 13ep. STREET ADDRESS |  | 13eq. STREET ADDRESS |  | 13er. STREET ADDRESS |  | 13es. STREET ADDRESS |  | 13et. STREET ADDRESS |  | 13eu. STREET ADDRESS |  | 13ev. STREET ADDRESS |  | 13ew. STREET ADDRESS |  | 13ex. STREET ADDRESS |  | 13ey. STREET ADDRESS |  | 13ez. STREET ADDRESS |  | 13fa. STREET ADDRESS |  | 13fb. STREET ADDRESS |  | 13fc. STREET ADDRESS |  | 13fd. STREET ADDRESS |  | 13fe. STREET ADDRESS |  | 13ff. STREET ADDRESS |  | 13fg. STREET ADDRESS |  | 13fh. STREET ADDRESS |  | 13fi. STREET ADDRESS |  | 13fj. STREET ADDRESS |  | 13fk. STREET ADDRESS |  | 13fl. STREET ADDRESS |  | 13fm. STREET ADDRESS |  | 13fn. STREET ADDRESS |  | 13fo. STREET ADDRESS |  | 13fp. STREET ADDRESS |  | 13fq. STREET ADDRESS |  | 13fr. STREET ADDRESS |  | 13fs. STREET ADDRESS |  | 13ft. STREET ADDRESS |  | 13fu. STREET ADDRESS |  | 13fv. STREET ADDRESS |  | 13fw. STREET ADDRESS |  | 13fx. STREET ADDRESS |  | 13fy. STREET ADDRESS |  | 13fz. STREET ADDRESS |  | 13ga. STREET ADDRESS |  | 13gb. STREET ADDRESS |  | 13gc. STREET ADDRESS |  | 13gd. STREET ADDRESS |  | 13ge. STREET ADDRESS |  | 13gf. STREET ADDRESS |  | 13gg. STREET ADDRESS |  | 13gh. STREET ADDRESS |  | 13gi. STREET ADDRESS |  | 13gj. STREET ADDRESS |  | 13gk. STREET ADDRESS |  | 13gl. STREET ADDRESS |  | 13gm. STREET ADDRESS |  | 13gn. STREET ADDRESS |  | 13go. STREET ADDRESS |  | 13gp. STREET ADDRESS |  | 13gq. STREET ADDRESS |  | 13gr. STREET ADDRESS |  | 13gs. STREET ADDRESS |  | 13gt. STREET ADDRESS |  | 13gu. STREET ADDRESS |  | 13gv. STREET ADDRESS |  | 13gw. STREET ADDRESS |  | 13gx. STREET ADDRESS |  | 13gy. STREET ADDRESS |  | 13gz. STREET ADDRESS |  | 13ha. STREET ADDRESS |  | 13hb. STREET ADDRESS |  | 13hc. STREET ADDRESS |  | 13hd. STREET ADDRESS |  | 13he. STREET ADDRESS |  | 13hf. STREET ADDRESS |  | 13hg. STREET ADDRESS |  | 13hh. STREET ADDRESS |  | 13hi. STREET ADDRESS |  | 13hj. STREET ADDRESS |  | 13hk. STREET ADDRESS |  | 13hl. STREET ADDRESS |  | 13hm. STREET ADDRESS |  | 13hn. STREET ADDRESS |  | 13ho. STREET ADDRESS |  | 13hp. STREET ADDRESS |  | 13hq. STREET ADDRESS |  | 13hr. STREET ADDRESS |  | 13hs. STREET ADDRESS |  | 13ht. STREET ADDRESS |  | 13hu. STREET ADDRESS |  | 13hv. STREET ADDRESS |  | 13hw. STREET ADDRESS |  | 13hx. STREET ADDRESS |  | 13hy. STREET ADDRESS |  | 13hz. STREET ADDRESS |  | 13ia. STREET ADDRESS |  | 13ib. STREET ADDRESS |  | 13ic. STREET ADDRESS |  | 13id. STREET ADDRESS |  | 13ie. STREET ADDRESS |  | 13if. STREET ADDRESS |  | 13ig. STREET ADDRESS |  | 13ih. STREET ADDRESS |  | 13ii. STREET ADDRESS |  | 13ij. STREET ADDRESS |  | 13ik. STREET ADDRESS |  | 13il. STREET ADDRESS |  | 13im. STREET ADDRESS |  | 13in. STREET ADDRESS |  | 13io. STREET ADDRESS |  | 13ip. STREET ADDRESS |  | 13iq. STREET ADDRESS |  | 13ir. STREET ADDRESS |  | 13is. STREET ADDRESS |  | 13it. STREET ADDRESS |  | 13iu. STREET ADDRESS |  | 13iv. STREET ADDRESS |  | 13iw. STREET ADDRESS |  | 13ix. STREET ADDRESS |  | 13iy. STREET ADDRESS |  | 13iz. STREET ADDRESS |  | 13ja. STREET ADDRESS |  | 13jb. STREET ADDRESS |  | 13jc. STREET ADDRESS |  | 13jd. STREET ADDRESS |  | 13je. STREET ADDRESS |  | 13jf. STREET ADDRESS |  | 13jg. STREET ADDRESS |  | 13jh. STREET ADDRESS |  | 13ji. STREET ADDRESS |  | 13jj. STREET ADDRESS |  | 13jk. STREET ADDRESS |  | 13jl. STREET ADDRESS |  | 13jm. STREET ADDRESS |  | 13jn. STREET ADDRESS |  | 13jo. STREET ADDRESS |  | 13jp. STREET ADDRESS |  | 13jq. STREET ADDRESS |  | 13jr. STREET ADDRESS |  | 13js. STREET ADDRESS |  | 13jt. STREET ADDRESS |  | 13ju. STREET ADDRESS |  | 13jv. STREET ADDRESS |  | 13jw. STREET ADDRESS |  | 13jx. STREET ADDRESS |  | 13jy. STREET ADDRESS |  | 13jz. STREET ADDRESS |  | 13ka. STREET ADDRESS |  | 13kb. STREET ADDRESS |  | 13kc. STREET ADDRESS |  | 13kd. STREET ADDRESS |  | 13ke. STREET ADDRESS |  | 13kf. STREET ADDRESS |  | 13kg. STREET ADDRESS |  | 13kh. STREET ADDRESS |  | 13ki. STREET ADDRESS |  | 13kj. STREET ADDRESS |  | 13kl. STREET ADDRESS |  | 13km. STREET ADDRESS |  | 13kn. STREET ADDRESS |  | 13ko. STREET ADDRESS |  | 13kp. STREET ADDRESS |  | 13kq. STREET ADDRESS |  | 13kr. STREET ADDRESS |  | 13ks. STREET ADDRESS |  | 13kt. STREET ADDRESS |  | 13ku. STREET ADDRESS |  | 13kv. STREET ADDRESS |  | 13kw. STREET ADDRESS |  | 13kx. STREET ADDRESS |  | 13ky. STREET ADDRESS |  | 13kz. STREET ADDRESS |  | 13la. STREET ADDRESS |  | 13lb. STREET ADDRESS |  | 13lc. STREET ADDRESS |  | 13ld. STREET ADDRESS |  | 13le. STREET ADDRESS |  | 13lf. STREET ADDRESS |  | 13lg. STREET ADDRESS |  | 13lh. STREET ADDRESS |  | 13li. STREET ADDRESS |  | 13lj. STREET ADDRESS |  | 13lk. STREET ADDRESS |  | 13ll. STREET ADDRESS |  | 13lm. STREET ADDRESS |  | 13ln. STREET ADDRESS |  | 13lo. STREET ADDRESS |  | 13lp. STREET ADDRESS |  | 13lq. STREET ADDRESS |  | 13lr. STREET ADDRESS |  | 13ls. STREET ADDRESS |  | 13lt. STREET ADDRESS |  | 13lu. STREET ADDRESS |  | 13lv. STREET ADDRESS |  | 13lw. STREET ADDRESS |  | 13lx. STREET ADDRESS |  | 13ly. STREET ADDRESS |  | 13lz. STREET ADDRESS |  | 13ma. STREET ADDRESS |  | 13mb. STREET ADDRESS |  | 13mc. STREET ADDRESS |  | 13md. STREET ADDRESS |  | 13me. STREET ADDRESS |  | 13mf. STREET ADDRESS |  | 13mg. STREET ADDRESS |  | 13mh. STREET ADDRESS |  | 13mi. STREET ADDRESS |  | 13mj. STREET ADDRESS |  | 13mk. STREET ADDRESS |  | 13ml. STREET ADDRESS |  | 13mn. STREET ADDRESS |  | 13mo. STREET ADDRESS |  | 13mp. STREET ADDRESS |  | 13mq. STREET ADDRESS |  | 13mr. STREET ADDRESS |  | 13ms. STREET ADDRESS |  | 13mt. STREET ADDRESS |  | 13mu. STREET ADDRESS |  | 13mv. STREET ADDRESS |  | 13mw. STREET ADDRESS |  | 13mx. STREET ADDRESS |  | 13my. STREET ADDRESS |  | 13mz. STREET ADDRESS |  | 13na. STREET ADDRESS |  | 13nb. STREET ADDRESS |  | 13nc. STREET ADDRESS |  | 13nd. STREET ADDRESS |  | 13ne. STREET ADDRESS |  | 13nf. STREET ADDRESS |  | 13ng. STREET ADDRESS |  | 13nh. STREET ADDRESS |  | 13ni. STREET ADDRESS |  | 13nj. STREET ADDRESS |  | 13nk. STREET ADDRESS |  | 13nl. STREET ADDRESS |  | 13nm. STREET ADDRESS |  | 13nn. STREET ADDRESS |  | 13no. STREET ADDRESS |  | 13np. STREET ADDRESS |  | 13nq. STREET ADDRESS |  | 13nr. STREET ADDRESS |  | 13ns. STREET ADDRESS |  | 13nt. STREET ADDRESS |  | 13nu. STREET ADDRESS |  | 13nv. STREET ADDRESS |  | 13nw. STREET ADDRESS |  | 13nx. STREET ADDRESS |  | 13ny. STREET ADDRESS |  | 13nz. STREET ADDRESS |  | 13oa. STREET ADDRESS |  | 13ob. STREET ADDRESS |  | 13oc. STREET ADDRESS |  | 13od. STREET ADDRESS |  | 13oe. STREET ADDRESS |  | 13of. STREET ADDRESS |  | 13og. STREET ADDRESS |  | 13oh. STREET ADDRESS |  | 13oi. STREET ADDRESS |  | 13oj. STREET ADDRESS |  | 13ok. STREET ADDRESS |  | 13ol. STREET ADDRESS |  | 13om. STREET ADDRESS |  | 13on. STREET ADDRESS |  | 13oo. STREET ADDRESS |  | 13op. STREET ADDRESS |  | 13oq. STREET ADDRESS |  | 13or. STREET ADDRESS |  | 13os. STREET ADDRESS |  | 13ot. STREET ADDRESS |  | 13ou. STREET ADDRESS |  | 13ov. STREET ADDRESS |  | 13ow. STREET ADDRESS |  | 13ox. STREET ADDRESS |  | 13oy. STREET ADDRESS |  | 13oz. STREET ADDRESS |  | 13pa. STREET ADDRESS |  | 13pb. STREET ADDRESS |  | 13pc. STREET ADDRESS |  | 13pd. STREET ADDRESS |  | 13pe. STREET ADDRESS |  | 13pf. STREET ADDRESS |  | 13pg. STREET ADDRESS |  | 13ph. STREET ADDRESS |  | 13pi. STREET ADDRESS |  | 13pj. STREET ADDRESS |  | 13pk. STREET ADDRESS |  | 13pl. STREET ADDRESS |  | 13pm. STREET ADDRESS |  | 13pn. STREET ADDRESS |  | 13po. STREET ADDRESS |  | 13pp. STREET ADDRESS |  | 13pq. STREET ADDRESS |  | 13pr. STREET ADDRESS |  | 13ps. STREET ADDRESS |  | 13pt. STREET ADDRESS |  | 13pu. STREET ADDRESS |  | 13pv. STREET ADDRESS |  | 13pw. STREET ADDRESS |  | 13px. STREET ADDRESS |  | 13py. STREET ADDRESS |  | 13pz. STREET ADDRESS |  | 13qa. STREET ADDRESS |  | 13qb. STREET ADDRESS |  | 13qc. STREET ADDRESS |  | 13qd. STREET ADDRESS |  | 13qe. STREET ADDRESS |  | 13qf. STREET ADDRESS |  | 13qg. STREET ADDRESS |  | 13qh. STREET ADDRESS |  | 13qi. STREET ADDRESS |  | 13qj. STREET ADDRESS |  | 13qk. STREET ADDRESS |  | 13ql. STREET ADDRESS |  | 13qm. STREET ADDRESS |  | 13qn. STREET ADDRESS |  | 13qo. STREET ADDRESS |  | 13qp. STREET ADDRESS |  | 13qq. STREET ADDRESS |  | 13qr. STREET ADDRESS |  | 13qs. STREET ADDRESS |  | 13qt. STREET ADDRESS |  | 13qu. STREET ADDRESS |  | 13qv. STREET ADDRESS |  | 13qw. STREET ADDRESS |  | 13qx. STREET ADDRESS |  | 13qy. STREET ADDRESS |  | 13qz. STREET ADDRESS |  | 13ra. STREET ADDRESS |  | 13rb. STREET ADDRESS |  | 13rc. STREET ADDRESS |  | 13rd. STREET ADDRESS |  | 13re. STREET ADDRESS |  | 13rf. STREET ADDRESS |  | 13rg. STREET ADDRESS |  | 13rh. STREET ADDRESS |  | 13ri. STREET ADDRESS |  | 13rj. STREET ADDRESS |  | 13rk. 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STREET ADDRESS |  | 13xh. STREET ADDRESS |  | 13xi. STREET ADDRESS |  | 13xj. STREET ADDRESS |  | 13xk. STREET ADDRESS |  | 13xl. STREET ADDRESS |  | 13xm. STREET ADDRESS |  | 13xn. STREET ADDRESS |  | 13xo. STREET ADDRESS |  | 13xp. STREET ADDRESS |  | 13xq. STREET ADDRESS |  | 13xr. STREET ADDRESS |  | 13xs. STREET ADDRESS |  | 13xt. STREET ADDRESS |  | 13xu. STREET ADDRESS |  | 13xv. STREET ADDRESS |  | 13xw. STREET ADDRESS |  | 13xx. STREET ADDRESS |  | 13xy. STREET ADDRESS |  | 13xz. STREET ADDRESS |  | 13ya. STREET ADDRESS |  | 13yb. STREET ADDRESS |  | 13yc. STREET ADDRESS |  | 13yd. STREET ADDRESS |  | 13ye. STREET ADDRESS |  | 13yf. STREET ADDRESS |  | 13yg. STREET ADDRESS |  | 13yh. STREET ADDRESS |  | 13yi. STREET ADDRESS |  | 13yj. STREET ADDRESS |  | 13yk. STREET ADDRESS |  | 13yl. STREET ADDRESS |  | 13ym. STREET ADDRESS |  | 13yn. STREET ADDRESS |  | 13yo. STREET ADDRESS |  | 13yp. STREET ADDRESS |  | 13yq. STREET ADDRESS |  | 13yr. STREET ADDRESS |  | 13ys. 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MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY: **Multiple injuries with complications**

IMMEDIATE CAUSE (a) **916-**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b)   
DUE TO, OR AS A CONSEQUENCE OF  
(c)   
DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  
20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH  
21b. TIME OF INJURY **3:57 P.M. 5 18 79**  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) **concrete block wall collapsed hitting victim**

21d. INJURY OCCURRED WHILE AT WORK ☒ NOT

PLATE I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7914680

|                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                           |                                                                                                                                                             |                            |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Richard D. Thomas Sr.</i>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>June 1 1979</i> |                                                                                                                                                             | 2b. HOUR<br><i>1:41 AM</i> |                                                                                                                            |  |
| 3 SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><i>White</i>                                                                                                                      |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6-23-11</i>                                                                                                        |                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>67</i><br>YRS. MONTHS DAYS HOURS MIN.                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penna.</i>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                               |                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>UNION MEMORIAL HOSPITAL</i> |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>                                                                          |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Secy.-Union</i>                                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>MD.</i>                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><i>Balto.</i>                                                                                                                |                                                           | 13c. CITY OR TOWN<br><i>Balto.</i>                                                                                                                          |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Edward Thomas</i>                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Esther Steele</i>                                                                       |                                                           | 13e. STREET ADDRESS<br><i>3807 Woodlea Avenue</i>                                                                                                           |                            | <i>21206</i>                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-14-2824</i>                                                               |                                                           | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Ruth E. Thomas - 3807 Woodlea Ave</i>                                                                                   |                            | <i>21206</i>                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Septic shock</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                             |                                                           |                                                                                                                                                             |                            |                                                                                                                            |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Carcinoma of Lung</i>                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                           |                                                                                                                                                             |                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                           |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                            |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>5/1/79</i> to <i>6/1/79</i> , that (1) (we) lost<br>saw the deceased alive on <i>6/1/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we (did) did not) view the body after death.                                                                            |  |                                                                                                                                             |                                                           |                                                                                                                                                             |                            |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Stuart Bell</i>                                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE<br><i>M.D.</i>                                                                                                                       |                                                           | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><i>6/1/79</i>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>STUART BELL</i>                                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br><i>UNION MEMORIAL HOSPITAL</i>                                                                                              |                                                           |                                                                                                                                                             |                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><i>6-4-79</i>                                                                                                                  |                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith Cem.</i>                                                                                          |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. MD.</i>                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc</i>                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS<br><i>6415 Belair Rd.</i>                                                                                                           |                                                           | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 5 1979</i>                                                                                                          |                            | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>                                                                        |  |

08041 47

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          | 2- DATE KNOWN OF DEATH                                             |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  | 7b HOUR             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------|--|---------------------------------------------|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST: Ronny, MIDDLE: L, LAST: Thomas                                                                                                                                                                                                                                                                                                                                                                             |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          | DATE KNOWN OF DEATH: MONTH 6, DAY 22, YEAR 1979                    |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  | 7b HOUR: 12:03 P.M. |  |
| 3. SEX: male                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE: white |  | 5. DATE OF BIRTH: MONTH 09, DAY 26, YEAR 1955                                                                                   |  |                                                                            | 6. AGE (IN YEARS): 23 YRS. |                                                                                                                                                          | IF UNDER 1 YR. MONTHS, DAYS, HOURS, MIN. |                                                                    | 7c. DATE PRONOUNCED DEAD: MONTH 6, DAY 23, YEAR 1979 |                                                                                  | 7d. HOUR: 12:03 P.M. |                                                                                              |  |                                             |  |  |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland                                                                                                                                                                                                                                                                                                                                                                                                   |  |                |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                                |  |                                                                            |                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                          |                                                                    |                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City, MD.                        |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH: Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3029 Huntington Avenue |  |                                                                            |                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinist                                                                                 |                                          |                                                                    |                                                      | 12b. KIND OF BUSINESS OR INDUSTRY: Spring Mfr                                    |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 13a. STATE: Md                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          | 13b. COUNTY: -                                                     |                                                      | 13c. CITY OR TOWN: Baltimore                                                     |                      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS: 3029 Huntington Avenue |  |  |  |                     |  |
| 14. FATHER'S NAME (FIRST, MIDDLE, LAST): Donald Eugene Thomas                                                                                                                                                                                                                                                                                                                                                                                         |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          | 15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST): Ann Louise Lindley |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no                                                                                                                                                                                                                                                                                                                                                                                |  |                |  | 16b. SOCIAL SECURITY NO.: 212 76 7781                                                                                           |  |                                                                            |                            | 17. INFORMANT: Donald E. Thomas                                                                                                                          |                                          |                                                                    |                                                      | ADDRESS: same                                                                    |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9505 IMMEDIATE CAUSE (a): Multiple Drug Intoxication<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                                         |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          |                                                                    |                                                      |                                                                                  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |  |                                             |  |  |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                   |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          |                                                                    |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                               |  |                                                                            |                            |                                                                                                                                                          |                                          |                                                                    |                                                      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                |  | 21b. TIME OF INJURY: HOUR 6, MONTH 6, DAY 22, YEAR 1979 P.M.                                                                    |  |                                                                            |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Self ingested                                                             |                                          |                                                                    |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                             |  |                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home                                                               |  |                                                                            |                            | 21f. LOCATION: 3029 Huntington Ave., Baltimore City, Md.                                                                                                 |                                          |                                                                    |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                |  |                                                                                                                                 |  |                                                                            |                            |                                                                                                                                                          |                                          |                                                                    |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| ACTUAL SIGNATURE: [Signature]                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                |  | TITLE (SPECIFY): Assistant                                                                                                      |  |                                                                            |                            | MEDICAL EXAMINER                                                                                                                                         |                                          |                                                                    |                                                      | DATE SIGNED: 6/24/79                                                             |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| EXAMINER'S NAME (TYPE OR PRINT): Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                                |  |                |  | ADDRESS: 111 Penn Street, Baltimore, MD                                                                                         |  |                                                                            |                            |                                                                                                                                                          |                                          |                                                                    |                                                      |                                                                                  |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial                                                                                                                                                                                                                                                                                                                                                                                                     |  |                |  | 23b. DATE: 6/27/79                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cemetery Woodlawn Balto. |                            |                                                                                                                                                          |                                          | 23d. LOCATION (CITY OR TOWN): Md                                   |                                                      | COUNTY: STATE:                                                                   |                      |                                                                                              |  |                                             |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR NAME: Burgee Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                        |  |                |  | ADDRESS: 3631 Falls Road 21211                                                                                                  |  |                                                                            |                            | 25a. DATE REC'D. BY REGISTRAR: JUN 25 1979                                                                                                               |                                          |                                                                    |                                                      | 25b. REGISTRAR'S SIGNATURE: [Signature]                                          |                      |                                                                                              |  |                                             |  |  |  |                     |  |

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2007-06-15



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79 14682

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                             |                                                                                        |                                                                                |                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sylvester C. Thomas</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-5-79</b>                                   |                                                                                | 2b. HOUR<br><b>4:35 PM</b>                            |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>White</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 12, 1921</b>                                                                                                   |                                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS                               |                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |                                                       |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TV Repair</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                        | 13c. CITY OR TOWN<br><b>1208 Fairfield Road</b>                                |                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Francis Thomas</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Roche</b>                    |                                                                                |                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>                                                                                                                                                                                                                                                                      |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>215 14 8847</b>                                                                                                              |                                                                                        | 17. INFORMANT<br><b>Nancy Thomas</b> ADDRESS<br><b>Same</b>                    |                                                       |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Cardio pulmonary arrest</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b): <b>Severe Anoxic Encephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c): <b>Prob. acute myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                    |                                                                                                                                                             |                                                                                        |                                                                                |                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                      |                                                                                                                                    |                                                                                                                                                             |                                                                                        |                                                                                |                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                                                                                                     |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/20</b> , 19 <b>79</b> , to <b>6/5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |                                                                                                                                    |                                                                                                                                                             |                                                                                        |                                                                                |                                                       |
| 22b. SIGNATURE<br><b>Juan Arguinzoni</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | DEGREE                                                                                                                                                      |                                                                                        | 22c. DATE SIGNED<br><b>6/5/79</b>                                              |                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Juan Arguinzoni</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    | 22e. ADDRESS<br><b>Sinai Hospital</b>                                                                                                                       |                                                                                        |                                                                                |                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    | 23b. DATE<br><b>6/8/79</b>                                                                                                                                  |                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                 |                                                       |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1979</b>                                                                                                          |                                                                                        | 23f. REGISTRAR'S SIGNATURE<br><b>Barbara K. Bandy</b>                          |                                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgess Funeral Home</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                    | 24b. ADDRESS<br><b>3631 Falls Road 21211</b>                                                                                                                |                                                                                        |                                                                                |                                                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1 - STATE  
REGISTRAR

THOMAS S. SEWELL

REG. NO.

79 14683

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                           |  |                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SEWELL THOMAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-24-79                                                                                                              |  |                                                                                                                           |  | 2b. HOUR<br>12 <sup>25</sup> A.M.             |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>W                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 3 1911                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                                                                 |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>AMERICA                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                      |  |                                               |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH CHARLES GENERAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br>BALTO                                                                                                               |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  | 13e. STREET ADDRESS<br>585 RITTERS LANE       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM SEWELL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAMMIE GUMPMAN                                                                                             |  |                                                                                                                           |  |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>213 058 559                                                                                            |  | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS                                                                                                                  |  |                                                                                                                           |  |                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary failure</u><br>5570<br>DUE TO, OR AS A CONSEQUENCE OF:<br>b) <u>Septic shock, myocardial infarction</u> 1 day<br>DUE TO, OR AS A CONSEQUENCE OF:<br>c) <u>Gangrene, left colon &amp; peritonitis</u> 1 day<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA &amp; left hemiparesis, hypertension, cancer of bladder &amp; larynx</u> |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION<br>6/22/79                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gangrene left colon, gastric ulcer                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                           |  |                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                           |  |                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/5/79</u> to <u>6/24/79</u> , that (I) (we) last saw the deceased alive on <u>6/24/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                           |  |                                               |  |
| 22b. SIGNATURE<br>Mauron Vallan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  | DEGREE<br>M.D.                                                                                                                                              |  |                                                                                                                           |  | 22c. DATE SIGNED<br>6/24/79                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAURON VALLAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 22e. ADDRESS<br>NORTH CHARLES + 28 <sup>TH</sup> STREET                                                                                                     |  |                                                                                                                           |  |                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>6-27-79                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MD.                                                        |  |                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | ADDRESS<br>8800 HARFORD RD.                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                                               |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy                                                                            |  |                                               |  |

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page]*



10/12/1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  | 79 14684<br>REG. NO.                                                                                                                                        |  |                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                         |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>SHELBY Jean THOMAS                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |  | June 16 1979                                                                                                                                                |  |                                                                                                                         |  |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>W                                                                                                                    |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOV. 27, 1938                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MD HOSP |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Account Clerk                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Patuxent Institute                                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br>MD HOWARD HANOVER                                                                                                                                                                                                                                                                                     |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                               |  | 13c. STREET ADDRESS<br>6405 Anderson Ave                                                                                                                    |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Christopher Cramer                                                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gladys Jedeline                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                         |  |                                                                                                                         |  |
| 16b. SOCIAL SECURITY NO.<br>213 384315                                                                                                                                                                                                                                                                                                                                                                                          |  | 17. INFORMANT<br>Floyd Thomas                                                                                                   |  |                                                                                                                                                             |  | ADDRESS<br>above                                                                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) VENTILATORY FAILURE<br>4151<br>DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLISM<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 HRS.<br>5 HRS. |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>BREAST CARCINOMA - METASTATIC                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (his hospital) attended the deceased from JUNE 15 19 79 to JUNE 16 19 79, that (I) (we) lost saw the deceased alive on JUNE 16 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                                                                                           |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br>M.D.                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>16 June 79                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES E. RIGGS, JR.                                                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br>22 S. GREENE ST. BALTIMORE, MD.                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>June 19, 1979                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowdale Memorial Park                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore MD                                                       |  |
| 24. FUNERAL DIRECTOR NAME<br>Dawson                                                                                                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br>Funeral Home                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                           |  | 7 9 1 4 6 8 5<br>REG. NO.                                                                              |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR                                     |  |
| EDITH                                                                                                                                                                                                                                                                                            |  | THOMPSON                                                                                               |  |                                                                                                                                                             |  |                                                                     |  | JUNE 4 1979                                                    |  | 9:07 PM                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                           |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS                              |  |
| Female                                                                                                                                                                                                                                                                                           |  | Black                                                                                                  |  | MONTH DAY YEAR<br>1 11 08                                                                                                                                   |  | 71 YRS.                                                             |  | MONTHS DAYS                                                    |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |                                              |  |
| Va.                                                                                                                                                                                                                                                                                              |  | U. S. A.                                                                                               |  |                                                                                                                                                             |  | BALTIMORE CITY                                                      |  |                                                                |  | MD.                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                                |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                        |  | JOHNS HOPKINS HOSPITAL                                                                                 |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                            |  |                                              |  |
| Md.                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | Baltimore                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1514 Madison St. Apt. 1                                        |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                |  | FIRST MIDDLE LAST                                                                                      |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| Smithery                                                                                                                                                                                                                                                                                         |  | Abby Jones                                                                                             |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |  |                                                                |  |                                              |  |
| No                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | Ernest Thompson                                                                                                                                             |  | 1514 Madison St. 1                                                  |  |                                                                |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Brain damage</u>                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  | ~10 hrs                                      |  |
| 2500 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>low serum glucose</u>                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetic mellitus</u>                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |
| 5/8/79                                                                                                                                                                                                                                                                                           |  | infected right foot                                                                                    |  |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                               |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                     |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                               |  | CITY OR TOWN                                                        |  | COUNTY                                                         |  | STATE                                        |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                |  |                                                                                                        |  | STREET                                                                                                                                                      |  |                                                                     |  |                                                                |  |                                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/29 19 79, to 6/4 19 79, that (1) (we) last saw the deceased alive on 6/4/79, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death. |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                             |  | DEGREE                                                              |  | 22c. DATE SIGNED                                               |  |                                              |  |
| Edward Frey MD                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  | 6/4/79                                                         |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                             |  | 22e. ADDRESS                                                        |  |                                                                |  |                                              |  |
| EDWARD FREY, MD                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                             |  | Johns Hopkins Hospital                                              |  |                                                                |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                        |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                       |  | CITY OR TOWN                                                   |  | COUNTY STATE                                 |  |
| Burial                                                                                                                                                                                                                                                                                           |  | 6/8/79                                                                                                 |  | Balto. Cem.                                                                                                                                                 |  | Baltimore                                                           |  |                                                                |  | Md.                                          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                                              |  |
| NAME ADDRESS<br>WM. C. MARCH F/H 1101 E. North Ave.                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                             |  | JUN 8 1979                                                          |  | P. J. McCready                                                 |  |                                              |  |

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[Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                               |  |                                                                                                                                  |  |                                                                                                                                                             |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                 |  | REG. NO. 9 1 4 6 8 6                                                                                                             |  |                                                                                                                                                             |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>THOMPSON, Lee E                                                                                                                                                                                                                              |  |                                                                                                                                  |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 8 79 |                                                                                              |  |                                                                                                                         |                                              | 2b. HOUR<br>9:35 PM |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>BLACK                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 14 1903                                                                                                               |                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS                                                    |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                           |                                              |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.                                       |  |                                                                                                                         |                                              |                     |
| 10. CITY OR TOWN OF DEATH<br>Balto                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland |  |                                                                                                                                                             |                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>R                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |                     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Maryland                                                                                                                                                                                     |  | 13b. COUNTY                                                                                                                      |  | 13c. CITY OR TOWN<br>Balto                                                                                                                                  |                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>911 West Lexington Street                                                                        |                                              |                     |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Thompson                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dorcas Holland                                                                     |  |                                                                                                                                                             |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>217-01-170217.01.170                                                                                 |  | 17. INFORMANT ADDRESS<br>Lee, E. Thompson 5911 W. Lexington St                                                                                              |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>431-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracerebral Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>48 hours</u>     |  |                                                                                                                                  |  |                                                                                                                                                             |                                            |                                                                                              |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                |  |                                                                                                                                  |  |                                                                                                                                                             |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  |                                                                                                                                                             |                                            | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7/79 to 6/8/79, that (I) (we) last saw the deceased alive on 6/8/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                  |  |                                                                                                                                                             |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 22b. SIGNATURE<br>Michael Sellman                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | DEGREE<br>MD                                                                                                                                                |                                            |                                                                                              |  | 22c. DATE SIGNED<br>6/8/79                                                                                              |                                              |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL SELLMAN                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 22e. ADDRESS<br>22 South Greene St Balto Md 21201                                                                                                           |                                            |                                                                                              |  |                                                                                                                         |                                              |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                |  | 23b. DATE<br>6-13-79                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn                                                                                                            |                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto Md                                          |  |                                                                                                                         |                                              |                     |
| 24. FUNERAL DIRECTOR NAME<br>Powell E. H. 312 N. Schroeder St                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                                                                                                |                                            | 25b. REGISTRAR'S SIGNATURE<br>L. H. Kelly                                                    |  |                                                                                                                         |                                              |                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7914687

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               |                                                                                      |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILLIE D. THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 8 1979</b>              |                                                                                                                                                             |                                                               | 2b. HOUR<br><b>8:45 P.M.</b>                                                         |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Negroid</b>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-21-1901</b>                                                                                                      |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS HOURS MIN<br><b>77</b>            |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ala.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |                                                |                                                                   |  |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               | 13b. COUNTY<br><b>Balto.</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Balto.</b>                            |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br><b>463 Cummings Ct.</b> |                                                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Dennard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Williams</b>                                                                                       |                                                               |                                                                                      |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>219-30-0254</b>                         |                                                                                                                                                             | 17. INFORMANT<br><b>June Jackson</b>                          |                                                                                      |                                                                                                 | ADDRESS<br><b>same</b>                                                                                                                     |                                                |                                                                   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b><br>2041<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>ACUTE RENAL FAILURE</b><br>3 DAYS<br>(c) <b>SEPSIS</b><br>6 DAYS                                                                                                            |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               |                                                                                      |                                                                                                 |                                                                                                                                            |                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>SINCE 1976</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               |                                                                                      |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                |                                                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 2</b> 19 <b>79</b> to <b>JUNE 8</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JUNE 8</b> 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               |                                                                                      |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 22b. SIGNATURE<br><b>Michael J. Quinn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               | DEGREE<br><b>MD</b>                                                                  |                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                | 22c. DATE SIGNED<br><b>6/9/79</b>                                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL J. QUINN M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               | 22e. ADDRESS<br><b>c/o MARYLAND GENERAL HOSPITAL</b>                                 |                                                                                                 |                                                                                                                                            |                                                |                                                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               | 23b. DATE<br><b>6-14-79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b> |                                                                                      |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                                                           |                                                |                                                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Donald E. Glover 1526 Moreland Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                  |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>                                                                                        |                                                |                                                                   |  |  |

1 4 2 8 1



JUNE 1972

LEWIS J. THOMPSON

BALTIMORE CITY

WILLIAM G. WILSON

WILLIAM G. WILSON

W-100

W-100

W-100

W-100

SIXTY 1972

CHRONIC DYSPEPTIC ILLNESS

1 DAY

ACUTE BILIAL PAIN

6 DAYS

RESULTS

JUNE 21 1972

JUNE 21 1972

JUNE 21 1972

WILLIAM G. WILSON

MICHAEL J. QUINN

W-100

W-100

W-100

W-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  | 7 9 1 4 6 8 8 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>OLLIE G. THOMPSON                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  |                                                                                                                                                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 22 79                                       |  | 2b. HOUR<br>10:50 A.M.                                                                                                     |  |               |  |
| 3 SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>white                                                                                                                |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 19 20                                                                                                               |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                            |  |                                                                                                                            |  |               |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  |                                                                                                                                                            |  | 13b. COUNTY                                                                          |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                             |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDGAR C. MADDOX                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ORA S. UNKNOWN                      |  |                                                                                                                            |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                  |  | (IF YES, GIVE WAR OR DATES)                                                                                                    |  | 16b. SOCIAL SECURITY NO<br>219-18-2871                                                                                                                     |  | 17. INFORMANT<br>ADDRESS<br>CHARLES R. THOMPSON, 507 SUNSET ROAD, 21223              |  |                                                                                                                            |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHIO - PNEUMONIA</u><br>4340<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <u>CEREBRO - VASCULAR THROMBOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ORGANIC BRAIN SYNDROME</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>years |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                             |  |                                                                                      |  |                                                                                                                            |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                      |  |                                                                                                                            |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 31</u> 19 <u>79</u> , to <u>June 22</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>June 22</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                  |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |               |  |
| 22b. SIGNATURE<br>C. d'ARCA NGUES                                                                                                                                                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br>6/22/79                                                          |  |                                                                                                                            |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. d'ARCA NGUES                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br>ST AGNES Hosp, 900 CATON RD, BALTO, Md 21229                                                                   |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>06-26-79                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ELKRIDGE HOWARD MD.                    |  |                                                                                                                            |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br>21229<br>4107 WILKENS AVE.                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McCreedy                                         |  |                                                                                                                            |  |               |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 6 9 0

REG NO

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  |                                                                                                                                                            |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------|
| 1 - FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                       |  | 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                  |  | FIRST<br>VERNON                                                                                                                                            | MIDDLE<br>C. | LAST<br>THORNE                                                                                 | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>6 3 79 |                                                                                                                           | 2b HOUR<br>2:30 A <sub>M</sub> |                              |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>WHITE                                                                                                                                     |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>3 2 19                                                                                                                |              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60<br>YRS.                                                   |                                              | 7 UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                | 8 UNDER 24 HRS<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                               |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |              | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                              |                                                                                                                           |                                |                              |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VETERANS ADMINISTRATION MEDICAL CENTER |  |                                                                                                                                                            |              | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CENTER                      |                                              | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |                                |                              |
| 13a USUAL RESIDENCE<br>13a STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b COUNTY                                                                                                                                          |  | 13c CITY OR TOWN<br>BALTIMORE                                                                                                                              |              | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              | 13e STREET ADDRESS<br>7100 Harford Road                                                                                   |                                |                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>W ILLIAM THORNE                                                                                                                                                                                                                                                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOUISE MARCH                                                                                        |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW 2                                                |              | 16b SOCIAL SECURITY NO<br>215 09 7734                                                          |                                              | 17 INFORMANT ADDRESS<br>VAMC Clinical Records Baltimore, Md. 21218                                                        |                                |                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Carcinoma of pharynx</u><br>1490<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>One month</u> |  |                                                                                                                                                     |  |                                                                                                                                                            |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                     |  |                                                                                                                                                            |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  |                                                                                                                                                            |              | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                              | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                         |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
| 22a I certify that (I) (this hospital) attended the deceased from MAY 1, 1979, to JUNE 3, 1979, that (I) (we) last saw the deceased alive on JUNE 3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                            |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
| 22b SIGNATURE<br><u>Donald Dennis</u>                                                                                                                                                                                                                                                                                                                                                                                               |  | DEGREE<br>M.D.                                                                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |              | 22c DATE SIGNED<br>6/6/79                                                                      |                                              |                                                                                                                           |                                |                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD DENNIS, M.D.                                                                                                                                                                                                                                                                                                                                                                         |  | 22e ADDRESS<br>3900 Loch Raven Blvd. Baltimore, Md. 21218                                                                                           |  |                                                                                                                                                            |              |                                                                                                |                                              |                                                                                                                           |                                |                              |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                            |  | 23b DATE<br>6-7-79                                                                                                                                  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery                                                                                                   |              | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                        |                                              |                                                                                                                           |                                |                              |
| 24 FUNERAL DIRECTOR<br>NAME<br>John C. Miller Inc-6415 Belair Rd.                                                                                                                                                                                                                                                                                                                                                                   |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 8 1979                                                                                                          |  | 25b REGISTRAR'S SIGNATURE<br><u>Pietro McCreedy</u>                                                                                                        |              |                                                                                                |                                              |                                                                                                                           |                                |                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14691

|                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                           |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                              |  | 2a. DATE OF DEATH                                                                                                                                                                                                                                                                                |  | MONTH                                                                                                                                                                                                                                                                                            |  | DAY                                                                                                                                                                                                                                                                                              |  | YEAR                                                                                                                                                                                                                                                                                             |  | 2b. HOUR                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  | CHARLES L. THURSTON                                                                                                                                                                                                                                                                              |  | 6                                                                                                                                                                                                                                                                                                |  | 26                                                                                                                                                                                                                                                                                               |  | 79                                                                                                                                                                                                                                                                                               |  | 6:05 P.M.                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 3. SEX                                                                                                                                                                                                                                                                                           |  | 4. RACE                                                                                                                                                                                                                                                                                          |  | 5. DATE OF BIRTH                                                                                                                                                                                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                                                                                                                                                                  |  | 7. IF UNDER 1 YEAR                                                                                                                                                                                                                                                                               |  | 8. IF UNDER 24 HRS                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| Male                                                                                                                                                                                                                                                                                             |  | White                                                                                                                                                                                                                                                                                            |  | July 19, 1906                                                                                                                                                                                                                                                                                    |  | 72 years                                                                                                                                                                                                                                                                                         |  | MONTHS                                                                                                                                                                                                                                                                                           |  | DAYS                                                                                                                                                                                                                                                                                             |  | HOURS                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| Virginia                                                                                                                                                                                                                                                                                         |  | U.S.A.                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                  |  | BALTIMORE CITY                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  | MD.                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                                                                                                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| BALTIMORE                                                                                                                                                                                                                                                                                        |  | ST AGNES HOSPITAL                                                                                                                                                                                                                                                                                |  | Vending Machine                                                                                                                                                                                                                                                                                  |  | Self                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                                                                                                                                                                                      |  | 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                |  | 13d. INSIDE CITY LIMITS?                                                                                                                                                                                                                                                                         |  | 13e. STREET ADDRESS                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| Md.                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                  |  | Baltimore                                                                                                                                                                                                                                                                                        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                              |  | 4713 Melbourne Road                                                                                                                                                                                                                                                                              |  | 21229                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                         |  | 17. INFORMANT                                                                                                                                                                                                                                                                                    |  | ADDRESS                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| Charles B. Thurston                                                                                                                                                                                                                                                                              |  | Olive Mitchell                                                                                                                                                                                                                                                                                   |  | NO                                                                                                                                                                                                                                                                                               |  | 216-01-9854                                                                                                                                                                                                                                                                                      |  | Mrs. Grace C. Thurston,                                                                                                                                                                                                                                                                          |  | 4713 Melbourne Road                                                                                                                                                                                                                                                                              |  | 21229                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |
| 410- Postero septal Myocardial Infarction                                                                                                                                                                                                                                                        |  | Atherosclerotic Cardiovascular                                                                                                                                                                                                                                                                   |  | Coronary                                                                                                                                                                                                                                                                                         |  | Complete Occlusion of artery                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                 |  | 20a. AUTOPSY?                                                                                                                                                                                                                                                                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                              |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                               |  | 21b. TIME OF INJURY                                                                                                                                                                                                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  | HOUR A.M. MONTH DAY YEAR                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  | P.M. 19                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY                                                                                                                                                                                                                                                                             |  | 21f. LOCATION                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                   |  | STREET                                                                                                                                                                                                                                                                                           |  | CITY OR TOWN                                                                                                                                                                                                                                                                                     |  | COUNTY                                                                                                                                                                                                                                                                                           |  | STATE                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost                                                                                                                                                                           |  | 22b. SIGNATURE                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                                                                                                                                                                                                                                           |  | 22c. DATE SIGNED                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                |  | V. Sukumar                                                                                                                                                                                                                                                                                       |  | MD                                                                                                                                                                                                                                                                                               |  | 6/27/79                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                            |  | 22e. ADDRESS                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                  |  | V. SUKUMAR                                                                                                                                                                                                                                                                                       |  | St. Agnes                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                        |  | 23b. DATE                                                                                                                                                                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                               |  | 23d. LOCATION                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| Burial                                                                                                                                                                                                                                                                                           |  | 6/29/79                                                                                                                                                                                                                                                                                          |  | Loudon Park Cemetery                                                                                                                                                                                                                                                                             |  | Baltimore City, Maryland                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| NAME                                                                                                                                                                                                                                                                                             |  | ADDRESS                                                                                                                                                                                                                                                                                          |  | JUN 28 1979                                                                                                                                                                                                                                                                                      |  | Hickory McCreedy                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |
| Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                       |  | 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                          |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  | REG. NO. 14692                                                                                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Benjamin Franklin Tillman</b>                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                          |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5 28 1979</b> | 2b. HOUR<br><b>6:30 P M</b> |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 4, 1916</b>                                                                                | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>62</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>5 2</b>                                                                                                                 | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 7 1979</b>                                   |  | 2d. HOUR<br><b>6:30 P M</b>                                                         |  |                                                                                                             |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                     |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |                                                                                     |  |                                                                                                             |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4204 Belview Avenue</b> |                                                        |                                                                                                                                                             |                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |                                                                                                             |                             |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                          |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 13b. COUNTY                                                                                                                              |                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4204 Belview Ave.</b>                                     |  |                                                                                                             |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Tillman</b>                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                          |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                             |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW 11</b>                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                          |                                                        | 16b. SOCIAL SECURITY NO.<br><b>215-09-1413</b>                                                                                                              |                                             | 17. INFORMANT ADDRESS<br><b>LaFrance Figueroa 2800 E. Chase St.</b>                             |  |                                                                                     |  |                                                                                                             |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                              |                         |                                                                                                                                          |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                |                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                          |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                                                             |                             |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                           |                         | 21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)                                                                               |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                                                          |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>                                                                                                                                                                                                                                                                                                                                                                                           |                         | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                      |                                                        | MEDICAL EXAMINER                                                                                                                                            |                                             | DATE SIGNED<br><b>6/8/79</b>                                                                    |  |                                                                                     |  |                                                                                                             |                             |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | ADDRESS<br><b>111 Penn Street</b>                                                                                                        |                                                        |                                                                                                                                                             |                                             |                                                                                                 |  |                                                                                     |  |                                                                                                             |                             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATED</b>                                                                                                                                                                                                                                                                                                                                                                        |                         | 23b. DATE<br><b>6-14-79</b>                                                                                                              |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>                                                                                             |                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |                                                                                     |  |                                                                                                             |                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anthony G. of Md. Balt. Md.</b>                                                                                                                                                                                                                                                                                                                                                                     |                         | ADDRESS                                                                                                                                  |                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |                                             | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony G. of Md.</i>                                          |  |                                                                                     |  |                                                                                                             |                             |

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MA

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **14693**

|                                                                                                 |  |                                   |  |                                              |  |                                      |  |                                         |  |                                                          |  |
|-------------------------------------------------------------------------------------------------|--|-----------------------------------|--|----------------------------------------------|--|--------------------------------------|--|-----------------------------------------|--|----------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                          |  | 2a. DATE KNOWN OF DEATH           |  | 2b. DATE KNOWN OF ESTI-MATED                 |  | 2c. DATE PRONOUNCED DEAD             |  | 2d. DATE KNOWN OF ESTI-MATED            |  | 2e. DATE PRONOUNCED DEAD                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                |  | 3. SEX                            |  | 4. RACE                                      |  | 5. DATE OF BIRTH                     |  | 6. AGE (IN YEARS)                       |  | 7. IF UNDER 1 YR                                         |  |
| WAYNE                                                                                           |  | Male                              |  | White                                        |  | Apr 1, 1946                          |  | 33 YRS.                                 |  | MONTHS DAYS HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?      |  | 8. MARRIED                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. CITY OR TOWN OF DEATH               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |
| Maryland                                                                                        |  | U.S.A                             |  | WIDOWED                                      |  | Baltimore City                       |  | Baltimore                               |  | Union Memorial Hospital                                  |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  | 12c. STREET ADDRESS                          |  | 12d. INSIDE CITY LIMITS?             |  | 12e. STREET ADDRESS                     |  | 12f. STREET ADDRESS                                      |  |
| Maryland                                                                                        |  | Inspector - Beth. Steel           |  | 130 West 40th Street 21211                   |  | YES                                  |  | 130 West 40th Street 21211              |  | 130 West 40th Street 21211                               |  |
| 14. FATHER'S NAME                                                                               |  | 15. MOTHER'S MAIDEN NAME          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |  | 16b. SOCIAL SECURITY NO.             |  | 17. INFORMANT                           |  | 18. ADDRESS                                              |  |
| James F. Timmons                                                                                |  | Jacqueline McCleary               |  | Yes                                          |  | 219-14-9677                          |  | Patricia Timmons-3D Shellmar Ct (21236) |  | Patricia Timmons-3D Shellmar Ct (21236)                  |  |

|                                                                                                          |  |                                              |  |
|----------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:                                                                              |  |                                              |  |
| IMMEDIATE CAUSE (a) <b>Broken neck</b>                                                                   |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                           |  |                                              |  |
| (b) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b> |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                           |  |                                              |  |
| (c)                                                                                                      |  |                                              |  |

|                                                                                                                                |  |                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  |                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |
| 19a. DATE OF OPERATION                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |
| 20. AUTOPSY?                                                                                                                   |  | 20. AUTOPSY?                                                                  |  |
| YES                                                                                                                            |  | NO                                                                            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING                                                                                             |  | 21b. TIME OF INJURY                                                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING                                                                                             |  | 21b. TIME OF INJURY                                                           |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                   |  |
| 21f. LOCATION                                                                                                                  |  | 21f. LOCATION                                                                 |  |
| 21f. LOCATION                                                                                                                  |  | 21f. LOCATION                                                                 |  |
| 21g. CITY OR TOWN                                                                                                              |  | 21g. CITY OR TOWN                                                             |  |
| 21g. CITY OR TOWN                                                                                                              |  | 21g. CITY OR TOWN                                                             |  |
| 21h. COUNTY                                                                                                                    |  | 21h. COUNTY                                                                   |  |
| 21h. COUNTY                                                                                                                    |  | 21h. COUNTY                                                                   |  |
| 21i. STATE                                                                                                                     |  | 21i. STATE                                                                    |  |
| 21i. STATE                                                                                                                     |  | 21i. STATE                                                                    |  |
| 21j. CITY OR TOWN                                                                                                              |  | 21j. CITY OR TOWN                                                             |  |
| 21j. CITY OR TOWN                                                                                                              |  | 21j. CITY OR TOWN                                                             |  |
| 21k. COUNTY                                                                                                                    |  | 21k. COUNTY                                                                   |  |
| 21k. COUNTY                                                                                                                    |  | 21k. COUNTY                                                                   |  |
| 21l. STATE                                                                                                                     |  | 21l. STATE                                                                    |  |
| 21l. STATE                                                                                                                     |  | 21l. STATE                                                                    |  |
| 21m. CITY OR TOWN                                                                                                              |  | 21m. CITY OR TOWN                                                             |  |
| 21m. CITY OR TOWN                                                                                                              |  | 21m. CITY OR TOWN                                                             |  |
| 21n. COUNTY                                                                                                                    |  | 21n. COUNTY                                                                   |  |
| 21n. COUNTY                                                                                                                    |  | 21n. COUNTY                                                                   |  |
| 21o. STATE                                                                                                                     |  | 21o. STATE                                                                    |  |
| 21o. STATE                                                                                                                     |  | 21o. STATE                                                                    |  |
| 21p. CITY OR TOWN                                                                                                              |  | 21p. CITY OR TOWN                                                             |  |
| 21p. CITY OR TOWN                                                                                                              |  | 21p. CITY OR TOWN                                                             |  |
| 21q. COUNTY                                                                                                                    |  | 21q. COUNTY                                                                   |  |
| 21q. COUNTY                                                                                                                    |  | 21q. COUNTY                                                                   |  |
| 21r. STATE                                                                                                                     |  | 21r. STATE                                                                    |  |
| 21r. STATE                                                                                                                     |  | 21r. STATE                                                                    |  |
| 21s. CITY OR TOWN                                                                                                              |  | 21s. CITY OR TOWN                                                             |  |
| 21s. CITY OR TOWN                                                                                                              |  | 21s. CITY OR TOWN                                                             |  |
| 21t. COUNTY                                                                                                                    |  | 21t. COUNTY                                                                   |  |
| 21t. COUNTY                                                                                                                    |  | 21t. COUNTY                                                                   |  |
| 21u. STATE                                                                                                                     |  | 21u. STATE                                                                    |  |
| 21u. STATE                                                                                                                     |  | 21u. STATE                                                                    |  |
| 21v. CITY OR TOWN                                                                                                              |  | 21v. CITY OR TOWN                                                             |  |
| 21v. CITY OR TOWN                                                                                                              |  | 21v. CITY OR TOWN                                                             |  |
| 21w. COUNTY                                                                                                                    |  | 21w. COUNTY                                                                   |  |
| 21w. COUNTY                                                                                                                    |  | 21w. COUNTY                                                                   |  |
| 21x. STATE                                                                                                                     |  | 21x. STATE                                                                    |  |
| 21x. STATE                                                                                                                     |  | 21x. STATE                                                                    |  |
| 21y. CITY OR TOWN                                                                                                              |  | 21y. CITY OR TOWN                                                             |  |
| 21y. CITY OR TOWN                                                                                                              |  | 21y. CITY OR TOWN                                                             |  |
| 21z. COUNTY                                                                                                                    |  | 21z. COUNTY                                                                   |  |
| 21z. COUNTY                                                                                                                    |  | 21z. COUNTY                                                                   |  |
| 21aa. STATE                                                                                                                    |  | 21aa. STATE                                                                   |  |
| 21aa. STATE                                                                                                                    |  | 21aa. STATE                                                                   |  |
| 21ab. CITY OR TOWN                                                                                                             |  | 21ab. CITY OR TOWN                                                            |  |
| 21ab. CITY OR TOWN                                                                                                             |  | 21ab. CITY OR TOWN                                                            |  |
| 21ac. COUNTY                                                                                                                   |  | 21ac. COUNTY                                                                  |  |
| 21ac. COUNTY                                                                                                                   |  | 21ac. COUNTY                                                                  |  |
| 21ad. STATE                                                                                                                    |  | 21ad. STATE                                                                   |  |
| 21ad. STATE                                                                                                                    |  | 21ad. STATE                                                                   |  |
| 21ae. CITY OR TOWN                                                                                                             |  | 21ae. CITY OR TOWN                                                            |  |
| 21ae. CITY OR TOWN                                                                                                             |  | 21ae. CITY OR TOWN                                                            |  |
| 21af. COUNTY                                                                                                                   |  | 21af. COUNTY                                                                  |  |
| 21af. COUNTY                                                                                                                   |  | 21af. COUNTY                                                                  |  |
| 21ag. STATE                                                                                                                    |  | 21ag. STATE                                                                   |  |
| 21ag. STATE                                                                                                                    |  | 21ag. STATE                                                                   |  |
| 21ah. CITY OR TOWN                                                                                                             |  | 21ah. CITY OR TOWN                                                            |  |
| 21ah. CITY OR TOWN                                                                                                             |  | 21ah. CITY OR TOWN                                                            |  |
| 21ai. COUNTY                                                                                                                   |  | 21ai. COUNTY                                                                  |  |
| 21ai. COUNTY                                                                                                                   |  | 21ai. COUNTY                                                                  |  |
| 21aj. STATE                                                                                                                    |  | 21aj. STATE                                                                   |  |
| 21aj. STATE                                                                                                                    |  | 21aj. STATE                                                                   |  |
| 21ak. CITY OR TOWN                                                                                                             |  | 21ak. CITY OR TOWN                                                            |  |
| 21ak. CITY OR TOWN                                                                                                             |  | 21ak. CITY OR TOWN                                                            |  |
| 21al. COUNTY                                                                                                                   |  | 21al. COUNTY                                                                  |  |
| 21al. COUNTY                                                                                                                   |  | 21al. COUNTY                                                                  |  |
| 21am. STATE                                                                                                                    |  | 21am. STATE                                                                   |  |
| 21am. STATE                                                                                                                    |  | 21am. STATE                                                                   |  |
| 21an. CITY OR TOWN                                                                                                             |  | 21an. CITY OR TOWN                                                            |  |
| 21an. CITY OR TOWN                                                                                                             |  | 21an. CITY OR TOWN                                                            |  |
| 21ao. COUNTY                                                                                                                   |  | 21ao. COUNTY                                                                  |  |
| 21ao. COUNTY                                                                                                                   |  | 21ao. COUNTY                                                                  |  |
| 21ap. STATE                                                                                                                    |  | 21ap. STATE                                                                   |  |
| 21ap. STATE                                                                                                                    |  | 21ap. STATE                                                                   |  |
| 21aq. CITY OR TOWN                                                                                                             |  | 21aq. CITY OR TOWN                                                            |  |
| 21aq. CITY OR TOWN                                                                                                             |  | 21aq. CITY OR TOWN                                                            |  |
| 21ar. COUNTY                                                                                                                   |  | 21ar. COUNTY                                                                  |  |
| 21ar. COUNTY                                                                                                                   |  | 21ar. COUNTY                                                                  |  |
| 21as. STATE                                                                                                                    |  | 21as. STATE                                                                   |  |
| 21as. STATE                                                                                                                    |  | 21as. STATE                                                                   |  |
| 21at. CITY OR TOWN                                                                                                             |  | 21at. CITY OR TOWN                                                            |  |
| 21at. CITY OR TOWN                                                                                                             |  | 21at. CITY OR TOWN                                                            |  |
| 21au. COUNTY                                                                                                                   |  | 21au. COUNTY                                                                  |  |
| 21au. COUNTY                                                                                                                   |  | 21au. COUNTY                                                                  |  |
| 21av. STATE                                                                                                                    |  | 21av. STATE                                                                   |  |
| 21av. STATE                                                                                                                    |  | 21av. STATE                                                                   |  |
| 21aw. CITY OR TOWN                                                                                                             |  | 21aw. CITY OR TOWN                                                            |  |
| 21aw. CITY OR TOWN                                                                                                             |  | 21aw. CITY OR TOWN                                                            |  |
| 21ax. COUNTY                                                                                                                   |  | 21ax. COUNTY                                                                  |  |
| 21ax. COUNTY                                                                                                                   |  | 21ax. COUNTY                                                                  |  |
| 21ay. STATE                                                                                                                    |  | 21ay. STATE                                                                   |  |
| 21ay. STATE                                                                                                                    |  | 21ay. STATE                                                                   |  |
| 21az. CITY OR TOWN                                                                                                             |  | 21az. CITY OR TOWN                                                            |  |
| 21az. CITY OR TOWN                                                                                                             |  | 21az. CITY OR TOWN                                                            |  |
| 21ba. COUNTY                                                                                                                   |  | 21ba. COUNTY                                                                  |  |
| 21ba. COUNTY                                                                                                                   |  | 21ba. COUNTY                                                                  |  |
| 21bb. STATE                                                                                                                    |  | 21bb. STATE                                                                   |  |
| 21bb. STATE                                                                                                                    |  | 21bb. STATE                                                                   |  |
| 21bc. CITY OR TOWN                                                                                                             |  | 21bc. CITY OR TOWN                                                            |  |
| 21bc. CITY OR TOWN                                                                                                             |  | 21bc. CITY OR TOWN                                                            |  |
| 21bd. COUNTY                                                                                                                   |  | 21bd. COUNTY                                                                  |  |
| 21bd. COUNTY                                                                                                                   |  | 21bd. COUNTY                                                                  |  |
| 21be. STATE                                                                                                                    |  | 21be. STATE                                                                   |  |
| 21be. STATE                                                                                                                    |  | 21be. STATE                                                                   |  |
| 21bf. CITY OR TOWN                                                                                                             |  | 21bf. CITY OR TOWN                                                            |  |
| 21bf. CITY OR TOWN                                                                                                             |  | 21bf. CITY OR TOWN                                                            |  |
| 21bg. COUNTY                                                                                                                   |  | 21bg. COUNTY                                                                  |  |
| 21bg. COUNTY                                                                                                                   |  | 21bg. COUNTY                                                                  |  |
| 21bh. STATE                                                                                                                    |  | 21bh. STATE                                                                   |  |
| 21bh. STATE                                                                                                                    |  | 21bh. STATE                                                                   |  |
| 21bi. CITY OR TOWN                                                                                                             |  | 21bi. CITY OR TOWN                                                            |  |
| 21bi. CITY OR TOWN                                                                                                             |  | 21bi. CITY OR TOWN                                                            |  |
| 21bj. COUNTY                                                                                                                   |  | 21bj. COUNTY                                                                  |  |
| 21bj. COUNTY                                                                                                                   |  | 21bj. COUNTY                                                                  |  |
| 21bk. STATE                                                                                                                    |  | 21bk. STATE                                                                   |  |
| 21bk. STATE                                                                                                                    |  | 21bk. STATE                                                                   |  |
| 21bl. CITY OR TOWN                                                                                                             |  | 21bl. CITY OR TOWN                                                            |  |
| 21bl. CITY OR TOWN                                                                                                             |  | 21bl. CITY OR TOWN                                                            |  |
| 21bm. COUNTY                                                                                                                   |  | 21bm. COUNTY                                                                  |  |
| 21bm. COUNTY                                                                                                                   |  | 21bm. COUNTY                                                                  |  |
| 21bn. STATE                                                                                                                    |  | 21bn. STATE                                                                   |  |
| 21bn. STATE                                                                                                                    |  | 21bn. STATE                                                                   |  |
| 21bo. CITY OR TOWN                                                                                                             |  | 21bo. CITY OR TOWN                                                            |  |
| 21bo. CITY OR TOWN                                                                                                             |  | 21bo. CITY OR TOWN                                                            |  |
| 21bp. COUNTY                                                                                                                   |  | 21bp. COUNTY                                                                  |  |
| 21bp. COUNTY                                                                                                                   |  | 21bp. COUNTY                                                                  |  |
| 21bq. STATE                                                                                                                    |  | 21bq. STATE                                                                   |  |
| 21bq. STATE                                                                                                                    |  | 21bq. STATE                                                                   |  |
| 21br. CITY OR TOWN                                                                                                             |  | 21br. CITY OR TOWN                                                            |  |
| 21br. CITY OR TOWN                                                                                                             |  | 21br. CITY OR TOWN                                                            |  |
| 21bs. COUNTY                                                                                                                   |  | 21bs. COUNTY                                                                  |  |
| 21bs. COUNTY                                                                                                                   |  | 21bs. COUNTY                                                                  |  |
| 21bt. STATE                                                                                                                    |  | 21bt. STATE                                                                   |  |
| 21bt. STATE                                                                                                                    |  | 21bt. STATE                                                                   |  |
| 21bu. CITY OR TOWN                                                                                                             |  | 21bu. CITY OR TOWN                                                            |  |
| 21bu. CITY OR TOWN                                                                                                             |  | 21bu. CITY OR TOWN                                                            |  |
| 21bv. COUNTY                                                                                                                   |  | 21bv. COUNTY                                                                  |  |
| 21bv. COUNTY                                                                                                                   |  | 21bv. COUNTY                                                                  |  |
| 21bw. STATE                                                                                                                    |  | 21bw. STATE                                                                   |  |
| 21bw. STATE                                                                                                                    |  | 21bw. STATE                                                                   |  |
| 21bx. CITY OR TOWN                                                                                                             |  | 21bx. CITY OR TOWN                                                            |  |
| 21bx. CITY OR TOWN                                                                                                             |  | 21bx. CITY OR TOWN                                                            |  |
| 21by. COUNTY                                                                                                                   |  | 21by. COUNTY                                                                  |  |
| 21by. COUNTY                                                                                                                   |  | 21by. COUNTY                                                                  |  |
| 21bz. STATE                                                                                                                    |  | 21bz. STATE                                                                   |  |
| 21bz. STATE                                                                                                                    |  | 21bz. STATE                                                                   |  |
| 21ca. CITY OR TOWN                                                                                                             |  | 21ca. CITY OR TOWN                                                            |  |
| 21ca. CITY OR TOWN                                                                                                             |  | 21ca. CITY OR TOWN                                                            |  |
| 21cb. COUNTY                                                                                                                   |  | 21cb. COUNTY                                                                  |  |
| 21cb. COUNTY                                                                                                                   |  | 21cb. COUNTY                                                                  |  |
| 21cc. STATE                                                                                                                    |  | 21cc. STATE                                                                   |  |
| 21cc. STATE                                                                                                                    |  | 21cc. STATE                                                                   |  |
| 21cd. CITY OR TOWN                                                                                                             |  | 21cd. CITY OR TOWN                                                            |  |
| 21cd. CITY OR TOWN                                                                                                             |  | 21cd. CITY OR TOWN                                                            |  |
| 21ce. COUNTY                                                                                                                   |  | 21ce. COUNTY                                                                  |  |
| 21ce. COUNTY                                                                                                                   |  | 21ce. COUNTY                                                                  |  |
| 21cd. STATE                                                                                                                    |  | 21cd. STATE                                                                   |  |
| 21cd. STATE                                                                                                                    |  | 21cd. STATE                                                                   |  |
| 21ce. CITY OR TOWN                                                                                                             |  | 21ce. CITY OR TOWN                                                            |  |
| 21ce. CITY OR TOWN                                                                                                             |  | 21ce. CITY OR TOWN                                                            |  |
| 21cf. COUNTY                                                                                                                   |  | 21cf. COUNTY                                                                  |  |
| 21cf. COUNTY                                                                                                                   |  | 21cf. COUNTY                                                                  |  |
| 21cg. STATE                                                                                                                    |  | 21cg. STATE                                                                   |  |
| 21cg. STATE                                                                                                                    |  | 21cg. STATE                                                                   |  |
| 21ch. CITY OR TOWN                                                                                                             |  | 21ch. CITY OR TOWN                                                            |  |
| 21ch. CITY OR TOWN                                                                                                             |  | 21ch. CITY OR TOWN                                                            |  |
| 21ci. COUNTY                                                                                                                   |  | 21ci. COUNTY                                                                  |  |
| 21ci. COUNTY                                                                                                                   |  | 21ci. COUNTY                                                                  |  |
| 21cj. STATE                                                                                                                    |  | 21cj. STATE                                                                   |  |
| 21cj. STATE                                                                                                                    |  | 21cj. STATE                                                                   |  |
| 21ck. CITY OR TOWN                                                                                                             |  | 21ck. CITY OR TOWN                                                            |  |
| 21ck. CITY OR TOWN                                                                                                             |  | 21ck. CITY OR TOWN                                                            |  |
| 21cl. COUNTY                                                                                                                   |  | 21cl. COUNTY                                                                  |  |
| 21cl. COUNTY                                                                                                                   |  | 21cl. COUNTY                                                                  |  |
| 21cm. STATE                                                                                                                    |  | 21cm. STATE                                                                   |  |
| 21cm. STATE                                                                                                                    |  | 21cm. STATE                                                                   |  |
| 21cn. CITY OR TOWN                                                                                                             |  | 21cn. CITY OR TOWN                                                            |  |
| 21cn. CITY OR TOWN                                                                                                             |  | 21cn. CITY OR TOWN                                                            |  |
| 21co. COUNTY                                                                                                                   |  | 21co. COUNTY                                                                  |  |
| 21co. COUNTY                                                                                                                   |  | 21co. COUNTY                                                                  |  |
| 21cp. STATE                                                                                                                    |  | 21cp. STATE                                                                   |  |
| 21cp. STATE                                                                                                                    |  | 21cp. STATE                                                                   |  |
| 21cq. CITY OR TOWN                                                                                                             |  | 21cq. CITY OR TOWN                                                            |  |
| 21cq. CITY OR TOWN                                                                                                             |  | 21cq. CITY OR TOWN                                                            |  |
| 21cr. COUNTY                                                                                                                   |  | 21cr. COUNTY                                                                  |  |
| 21cr. COUNTY                                                                                                                   |  | 21cr. COUNTY                                                                  |  |
| 21cs. STATE                                                                                                                    |  | 21cs. STATE                                                                   |  |
| 21cs. STATE                                                                                                                    |  | 21cs. STATE                                                                   |  |
| 21ct. CITY OR TOWN                                                                                                             |  | 21ct. CITY OR TOWN                                                            |  |
| 21ct. CITY OR TOWN                                                                                                             |  | 21ct. CITY OR TOWN                                                            |  |
| 21cu. COUNTY                                                                                                                   |  | 21cu. COUNTY                                                                  |  |
| 21cu. COUNTY                                                                                                                   |  | 21cu. COUNTY                                                                  |  |
| 21cv. STATE                                                                                                                    |  | 21cv. STATE                                                                   |  |
| 21cv. STATE                                                                                                                    |  | 21cv. STATE                                                                   |  |
| 21cw. CITY OR TOWN                                                                                                             |  | 21cw. CITY OR TOWN                                                            |  |
| 21cw. CITY OR TOWN                                                                                                             |  | 21cw. CITY OR TOWN                                                            |  |
| 21cx. COUNTY                                                                                                                   |  | 21cx. COUNTY                                                                  |  |
| 21cx. COUNTY                                                                                                                   |  | 21cx. COUNTY                                                                  |  |
| 21cy. STATE                                                                                                                    |  | 21cy. STATE                                                                   |  |
| 21cy. STATE                                                                                                                    |  | 21cy. STATE                                                                   |  |
| 21cz. CITY OR TOWN                                                                                                             |  | 21cz. CITY OR TOWN                                                            |  |
| 21cz. CITY OR TOWN                                                                                                             |  | 21cz. CITY OR TOWN                                                            |  |
| 21da. COUNTY                                                                                                                   |  | 21da. COUNTY                                                                  |  |
| 21da. COUNTY                                                                                                                   |  | 21da. COUNTY                                                                  |  |
| 21db. STATE                                                                                                                    |  | 21db. STATE                                                                   |  |
| 21db. STATE                                                                                                                    |  | 21db. STATE                                                                   |  |
| 21dc. CITY OR TOWN                                                                                                             |  | 21dc. CITY OR TOWN                                                            |  |
| 21dc. CITY OR TOWN                                                                                                             |  | 21dc. CITY OR TOWN                                                            |  |
| 21dd. COUNTY                                                                                                                   |  | 21dd. COUNTY                                                                  |  |
| 21dd. COUNTY                                                                                                                   |  | 21dd. COUNTY                                                                  |  |
| 21de. STATE                                                                                                                    |  | 21de. STATE                                                                   |  |
| 21de. STATE                                                                                                                    |  | 21de. STATE                                                                   |  |
| 21df. CITY OR TOWN                                                                                                             |  | 21df. CITY OR TOWN                                                            |  |
| 21df. CITY OR TOWN                                                                                                             |  | 21df. CITY OR TOWN                                                            |  |
| 21dg. COUNTY                                                                                                                   |  | 21dg. COUNTY                                                                  |  |
| 21dg. COUNTY                                                                                                                   |  | 21dg. COUNTY                                                                  |  |
| 21dh. STATE                                                                                                                    |  | 21dh. STATE                                                                   |  |
| 21dh. STATE                                                                                                                    |  | 21dh. STATE                                                                   |  |
| 21di. CITY OR TOWN                                                                                                             |  | 21di. CITY OR TOWN                                                            |  |
| 21di. CITY OR TOWN                                                                                                             |  | 21di. CITY OR TOWN                                                            |  |
| 21dj. COUNTY                                                                                                                   |  | 21dj. COUNTY                                                                  |  |
| 21dj. COUNTY                                                                                                                   |  | 21dj. COUNTY                                                                  |  |
| 21dk. STATE                                                                                                                    |  | 21dk. STATE                                                                   |  |
| 21dk. STATE                                                                                                                    |  | 21dk. STATE                                                                   |  |
| 21dl. CITY OR TOWN                                                                                                             |  | 21dl. CITY OR TOWN                                                            |  |
| 21dl. CITY OR TOWN                                                                                                             |  | 21dl. CITY OR TOWN                                                            |  |
| 21dm. COUNTY                                                                                                                   |  | 21dm. COUNTY                                                                  |  |
| 21dm. COUNTY                                                                                                                   |  | 21dm. COUNTY                                                                  |  |
| 21dn. STATE                                                                                                                    |  | 21dn. STATE                                                                   |  |
| 21dn. STATE                                                                                                                    |  | 21dn. STATE                                                                   |  |
| 21do. CITY OR TOWN                                                                                                             |  | 21do. CITY OR TOWN                                                            |  |
| 21do. CITY OR TOWN                                                                                                             |  | 21do. CITY OR TOWN                                                            |  |
| 21dp. COUNTY                                                                                                                   |  | 21dp. COUNTY                                                                  |  |
| 21dp. COUNTY                                                                                                                   |  | 21dp. COUNTY                                                                  |  |
| 21dq. STATE                                                                                                                    |  | 21dq. STATE                                                                   |  |
| 21dq. STATE                                                                                                                    |  | 21dq. STATE                                                                   |  |
| 21dr. CITY OR TOWN                                                                                                             |  | 21dr. CITY OR TOWN                                                            |  |
| 21dr. CITY OR TOWN                                                                                                             |  | 21dr. CITY OR TOWN                                                            |  |
| 21ds. COUNTY                                                                                                                   |  | 21ds. COUNTY                                                                  |  |
| 21ds. COUNTY                                                                                                                   |  | 21ds. COUNTY                                                                  |  |
| 21dt. STATE                                                                                                                    |  | 21dt. STATE                                                                   |  |
| 21dt. STATE                                                                                                                    |  | 21dt. STATE                                                                   |  |
| 21du. CITY OR TOWN                                                                                                             |  | 21du. CITY OR TOWN                                                            |  |
| 21du. CITY OR TOWN                                                                                                             |  | 21du. CITY OR TOWN                                                            |  |
| 21dv. COUNTY                                                                                                                   |  | 21dv. COUNTY                                                                  |  |
| 21dv. COUNTY                                                                                                                   |  | 21dv. COUNTY                                                                  |  |
| 21du. STATE                                                                                                                    |  | 21du. STATE                                                                   |  |
| 21du. STATE                                                                                                                    |  | 21du. STATE                                                                   |  |
| 21dv. CITY OR TOWN                                                                                                             |  | 21dv. CITY OR TOWN                                                            |  |
| 21dv. CITY OR TOWN                                                                                                             |  | 21dv. CITY OR TOWN                                                            |  |
| 21dw. COUNTY                                                                                                                   |  | 21dw. COUNTY                                                                  |  |
| 21dw. COUNTY                                                                                                                   |  | 21dw. COUNTY                                                                  |  |
| 21dx. STATE                                                                                                                    |  | 21dx. STATE                                                                   |  |
| 21dx. STATE                                                                                                                    |  | 21dx. STATE                                                                   |  |
| 21dy. CITY OR TOWN                                                                                                             |  | 21dy. CITY OR TOWN                                                            |  |
| 21dy. CITY OR TOWN                                                                                                             |  | 21dy. CITY OR TOWN                                                            |  |
| 21dz. COUNTY                                                                                                                   |  | 21dz. COUNTY                                                                  |  |
| 21dz. COUNTY                                                                                                                   |  | 21dz. COUNTY                                                                  |  |
| 21dy. STATE                                                                                                                    |  | 21dy. STATE                                                                   |  |
| 21dy. STATE                                                                                                                    |  | 21dy. STATE                                                                   |  |
| 21dz. CITY OR TOWN                                                                                                             |  | 21dz. CITY OR TOWN                                                            |  |
| 21dz. CITY OR TOWN                                                                                                             |  | 21dz. CITY OR TOWN                                                            |  |
| 21ea. COUNTY                                                                                                                   |  | 21ea. COUNTY                                                                  |  |
| 21ea. COUNTY                                                                                                                   |  | 21ea. COUNTY                                                                  |  |
| 21eb. STATE                                                                                                                    |  | 21eb. STATE                                                                   |  |
| 21eb. STATE                                                                                                                    |  | 21eb. STATE                                                                   |  |
| 21ec. CITY OR TOWN                                                                                                             |  | 21ec. CITY OR TOWN                                                            |  |
| 21ec. CITY OR TOWN                                                                                                             |  | 21ec. CITY OR TOWN                                                            |  |
| 21ed. COUNTY                                                                                                                   |  | 21ed. COUNTY                                                                  |  |
| 21ed. COUNTY                                                                                                                   |  | 21ed. COUNTY                                                                  |  |
| 21ee. STATE                                                                                                                    |  | 21ee. STATE                                                                   |  |
| 21ee. STATE                                                                                                                    |  | 21ee. STATE                                                                   |  |
| 21ef. CITY OR TOWN                                                                                                             |  | 21ef. CITY OR TOWN                                                            |  |
| 21ef. CITY OR TOWN                                                                                                             |  | 21ef. CITY OR TOWN                                                            |  |
| 21ed. COUNTY                                                                                                                   |  | 21ed. COUNTY                                                                  |  |
| 21ed. COUNTY                                                                                                                   |  | 21ed. COUNTY                                                                  |  |
| 21ee. STATE                                                                                                                    |  | 21ee. STATE                                                                   |  |
| 21ee. STATE                                                                                                                    |  | 21ee. STATE                                                                   |  |
| 21ef. CITY OR TOWN                                                                                                             |  |                                                                               |  |

08041 4A

08041 4A





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 6 9 4

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BLANCHE TISSENBAUM                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             | 2a. DATE OF DEATH<br>JUNE 30, 1979                                     |                                                                                                                                                             |                                                                                | 2b. HOUR<br>7:30 P M                                                                 |                                                                                                 |                                                                                                                            |                                                       |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>WHITE                                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 14 1891                                                                                                             |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS                                            |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>LITHUANIA                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                         |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                                                 |                                                                                                                            |                                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3634 FORDS LANE APT. D (21215) |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                                                                                  |                                                       |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>BALTIMORE                                                 |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>3634 FORDS LANE APT. D (21215) |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRA MENDEL BROWN                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROCHELL BENJAMIN                                                                                           |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>DAVID TISSENBAUM 3634 FORDS LANE (21215)           |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) ASHD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 hrs.<br>YRS. |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1968, 19, to 6/30, 1979, that (I) (we) lost saw the deceased alive on 6/30, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                  |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 22b. SIGNATURE<br>M.D.                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | DEGREE<br>M.D.                                                                 |                                                                                      |                                                                                                 | 22c. DATE SIGNED<br>7/1/79                                                                                                 |                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MORTON M. MOWER                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>200 W. COLD SPRING LANE                                        |                                                                                      |                                                                                                 |                                                                                                                            |                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 23b. DATE<br>JULY 2, 1979                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH CONG.                        |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN MD.                                      |                                                                                                                            |                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 24b. ADDRESS<br>6040 REISTERSTOWN RD<br>BALTIMORE, MD. 21215                   |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979                                                     |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>[Signature]             |  |

MEDICAL CERTIFICATION

NO

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE NEW YORK  
PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION  
125 WEST 47TH STREET  
NEW YORK 18



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 1

79 14695

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                  |                                                                                                                                                             |                                                           |                                                                                                 |                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |                                                                                  | 2a. DATE OF DEATH                                                                                                                                           |                                                           | 2b. HOUR                                                                                        |                                                       |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ROBERT ANDERSON TODD                                                                                                                                                                                                                                                                                                           |                                                                                  | June 30th, 1979                                                                                                                                             |                                                           | Approx 11 PM                                                                                    |                                                       |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br>White                                                                 | 5. DATE OF BIRTH<br>MONTH June DAY 23rd YEAR 1920                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Monroeville, Pa.                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |                                                                                                 |                                                       |
| 10. CITY OR TOWN OF DEATH<br>Balto City                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Union Memorial Hospt. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>Electronic Buyer                 |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                     |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                  |                                                                                  | 13b. COUNTY<br>Balto                                                                                                                                        | 13c. CITY OR TOWN                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>7 Edgemoor Rd.                 |
| 14. FATHER'S NAME<br>Robert G. Todd                                                                                                                                                                                                                                                                                                                                |                                                                                  | 15. MOTHER'S MAIDEN NAME<br>Isabel Wilson                                                                                                                   |                                                           | 16. ADDRESS<br>Mrs. Margaret M. Todd-7 Edgemoor Rd.                                             |                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>YES                                                                                                                                                                                                                                                                                                                |                                                                                  | 16b. SOCIAL SECURITY NO.<br>215-05-7917                                                                                                                     |                                                           | 17. INFORMANT<br>Mrs. Margaret M. Todd-7 Edgemoor Rd.                                           |                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Coronary Occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Cardiovascular Disease</u>                                     |                                                                                  |                                                                                                                                                             |                                                           |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hyperlipidemia</u>                                                                                                                                                                                                      |                                                                                  |                                                                                                                                                             |                                                           |                                                                                                 |                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                          |                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/79</u> 19 <u>76</u> to <u>June 14</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                  |                                                                                                                                                             |                                                           |                                                                                                 |                                                       |
| 22b. SIGNATURE<br><u>Felix Tan</u>                                                                                                                                                                                                                                                                                                                                 |                                                                                  | DEGREE<br><u>M.D.</u>                                                                                                                                       |                                                           | 22c. DATE SIGNED<br><u>7/2/79</u>                                                               |                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Felix Tan, M.D.                                                                                                                                                                                                                                                                                                           |                                                                                  | 22e. ADDRESS<br>3800 Erdman Avenue 21213                                                                                                                    |                                                           |                                                                                                 |                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                |                                                                                  | 23b. DATE<br>7/3/79                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.       |                                                                                                 | 23d. LOCATION<br>BALTO Co. COUNTY STATE               |
| 24. FUNERAL DIRECTOR<br>NAME Mitchell-Wiedefeld Home-6500 York Rd. 21212 ADDRESS                                                                                                                                                                                                                                                                                   |                                                                                  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUL 5 1979               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Hickory McCreedy</u> |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14696

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                        |                                                                    |                                                                                                                                                             |                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWARD THOMAS TOLAN                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>6 1 1979 |                                                                                                                                                             | 2b. HOUR<br>M<br>6:45 P                                                             |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 24, 1922                    | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>56 YRS                       | IF UNDER 1 YR.<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN                                                                                              | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 2 1979                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS                                                                                                                                                                                                                                                                                                                                                                                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                     |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                                                                                                                                                                                                                                                                                                  |                  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                 |                                                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>216 W. Monument St.                           |                                                                                     |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CUSTODIAN                                                                                                                                                                                                                                                                                                                                                                  |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |                                                                    | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                                     |
| 13b. STREET ADDRESS<br>216 W. MONUMENT ST.                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS A. TOLAN              |                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ALICE B.                                                                                                   |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                                                                                |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>023-14-7262 |                                                                    | 17. INFORMANT ADDRESS<br>GERARD E. HEEGAN 1101 W. LAKE AVE.                                                                                                 |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                 |                  |                                                                        |                                                                    |                                                                                                                                                             |                                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                         |                  |                                                                        |                                                                    |                                                                                                                                                             |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |                                                                    |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19                                                                                                                                                                                                                                                                                                           |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |                                                                    | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                  |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |                                                                        |                                                                    |                                                                                                                                                             |                                                                                     |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                      |                  | TITLE (SPECIFY)<br>M.D. Assistant                                      |                                                                    | MEDICAL EXAMINER<br>DATE SIGNED 6-3-79                                                                                                                      |                                                                                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |                  | ADDRESS<br>111 Penn St.                                                |                                                                    |                                                                                                                                                             |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                      |                  | 23b. DATE<br>JUNE 7, 1979                                              |                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>NEWTON CEMETERY                                                                                                       |                                                                                     |
| 23d. LOCATION<br>CITY OR TOWN<br>NEWTON                                                                                                                                                                                                                                                                                                                                                                                                     |                  | COUNTY<br>MASS.                                                        |                                                                    | STATE                                                                                                                                                       |                                                                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME                                                                                                                                                                                                                                                                                                                                                                                     |                  | ADDRESS<br>6500 YORK RD.                                               |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                                                                                                 |                                                                                     |
| 25b. REGISTRAR'S SIGNATURE<br>Rafael McBrady                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                        |                                                                    |                                                                                                                                                             |                                                                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

(M)

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                                             | 7 9 1 4 6 9 7<br>REG. NO.                                                                                                                            |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SADIE MIRIAM TRATTLER</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06-15-79</b>                                                                                               |                                                                                       |                                                                                                                            | 2b. HOUR<br>P. M.<br><b>10:10</b>                               |                                                                                                 |  |
| 3. SEX<br><b>F FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>WHITE</b>                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 28 04</b>                                                                                                       |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>                                          |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |                                                                                                                            |                                                                 |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESWOMAN</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRESS SHOP</b>          |                                                                                                 |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                      |                                                                                       | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                      |                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS ISAACS</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>TOBY UNKNOWN</b>                                                                                 |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>266-18-7054A</b>                                                                                    |  | 17. INFORMANT <b>ABRAHAM TRATTLER</b><br><b>6921 GLEN HEIGHTS RD. #21215</b>                                                                                |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AORTIC INSUFF - AORTIC STENOSIS</b><br><b>3952</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>RHEUMATIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>05-15-79</b> , to <b>06-15-79</b> , that (I) (we) lost<br>saw the deceased alive on <b>06-15-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                  |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 22b. SIGNATURE<br><b>Cesar E. Gamboa</b> MD -                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                       |                                                                                                                            | 22c. DATE SIGNED<br><b>06-15-79</b>                             |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR E. GAMBOA, MD</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  |                                                                                                                                                             | 22e. ADDRESS<br><b>906 SINAI HOSPITAL</b>                                                                                                            |                                                                                       |                                                                                                                            |                                                                 |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>JUNE 17, 1979</b>                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH ISAAC ADATH ISRAEL</b>                                                                                        |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>               |                                                                                                                            |                                                                 |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                                                                                  |                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McBratney</b>                                                                      |                                                                 |                                                                                                 |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE THIS CERTIFICATE WITH THE REGISTRAR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14698

|                                                                                                                                                                                                                                                                                                                                                                        |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------|--|--------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-----------------------------------|--|----|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                 |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH                                                                                                            |  | 2b. HOUR                                                                            |  |                                   |  |    |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAMES W. TRAYNHAM</b>                                                                                                                                                                                                                                                                                          |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  | DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 13 79</b>                               |  | 7b. HOUR<br><b>10:11</b>                                                            |  |                                   |  |    |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br><b>black</b> |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>11 15 22</b>                                    |  | 6 AGE (IN YEARS) LAST BIRTHDAY<br><b>56 YRS.</b>                             |  | IF UNDER 1 YR. MONTHS DAYS<br><b>0 0</b>                                                                                                                    |  | IF UNDER 24 HRS. HOURS MIN<br><b>0 0</b>                                                                                           |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>6 13 79</b>                           |  | 10:11 A M                         |  |    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>                                                                                                                                                                                                                                                                                                                |  |                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                           |  |                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  |                                   |  | MD |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                           |  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>506 Sanford Place</b> |  |                                                                              |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                      |  |                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                             |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>506 Sanford Pl.</b>                                       |  |                                   |  |    |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY            |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                   |  |                                                                              |  |                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James W. Traynham, Sr.</b>                                                                                                                                                                                                                                                                                                   |  |                        |  |                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Celestine G. Nottingham</b> |  |                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                       |  |                        |  | 16b. SOCIAL SECURITY NO.<br><b>230-01-7139</b>                                       |  | 17. INFORMANT ADDRESS<br><b>Margaret Traynham 506 Sanford Pl.</b>            |  |                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>Hypertensive arteriosclerotic cardiovascular disease</b><br>IMMEDIATE CAUSE (a) <del>XXXXXXXXXXXX</del><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |                                                                                     |  |                                   |  |    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                         |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |  |                                                                              |  |                                                                                                                                                             |  |                                                                                                                                    |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |  |    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                    |  |                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                       |  |                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                               |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                          |  |                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                    |  |                        |  |                                                                                      |  |                                                                              |  |                                                                                                                                                             |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                                                                                     |  |                                   |  |    |  |
| ACTUAL SIGNATURE<br><i>Margareta A. Korell</i>                                                                                                                                                                                                                                                                                                                         |  |                        |  | TITLE (SPECIFY)<br><b>Assistant</b>                                                  |  |                                                                              |  | MEDICAL EXAMINER                                                                                                                                            |  |                                                                                                                                    |  | DATE SIGNED<br><b>6/13/79</b>                                                       |  |                                   |  |    |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                    |  |                        |  | ADDRESS<br><b>111 Penn Street</b>                                                    |  |                                                                              |  |                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                     |  |                                   |  |    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                             |  |                        |  | 23b. DATE<br><b>6/18/79</b>                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>               |  |                                                                                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>                                                                |  |                                                                                     |  |                                   |  |    |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                     |  |                        |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                 |  |                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |  |                                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |  |                                   |  |    |  |

SECRET



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                          |                                                                                                                                                             |                                                                                   |                                                                                   |                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SARAH SOPHIA TRAYSER</b>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                          |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR <b>6 7 79</b> 2b. HOUR <b>7:00 A.M.</b>          |                                                                                   |                                                  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><b>WHITE</b>                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 18 97</b>                                                                                                           |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b><br>YRS MONTH DAYS HOURS MIN             |                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                 |                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>-</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                   |                                                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |                                                                                   | 13e. STREET ADDRESS <b>3201 E. Monument Street</b> 21205                          |                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>- - Edenfield</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>UNKNOWN</b>                                                                                                |                                                                                   |                                                                                   |                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                          | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>                                                                            | 17. INFORMANT ADDRESS <b>Philip Trayser (son) same as 13</b>                                                                                                |                                                                                   |                                                                                   |                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b> |                                                                                                                                          |                                                                                                                                                             |                                                                                   |                                                                                   |                                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                 |                                                                                                                                          |                                                                                                                                                             |                                                                                   |                                                                                   |                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-28</b> 19 <b>79</b> to <b>6-6</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6-6</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                       |                                                                                                                                          |                                                                                                                                                             |                                                                                   |                                                                                   |                                                  |
| 22b. SIGNATURE<br><b>R. Chen-Tan</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                          | DEGREE <b>MD</b>                                                                                                                                            |                                                                                   | 22c. DATE SIGNED                                                                  |                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. CHEN-TAN</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                          | 22e. ADDRESS<br><b>Baltimore City Hospital</b>                                                                                                              |                                                                                   |                                                                                   |                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                          | 23b. DATE<br><b>6/11/79</b>                                                                                                                                 |                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                   |                                                  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                          | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                                                         |                                                                                   | 23f. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>                               |                                                  |
| 24. FUNERAL DIRECTOR<br>Name <b>Schmittnek Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                          | 25. ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21213</b>                                                                                                     |                                                                                   |                                                                                   |                                                  |

REPORT



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 14700

|                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                              |                                                                                                                                                            |                                                                                |                                                                                                 |                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LURA H. TREASURE                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/25/79                                                                                                             |                                                                                | 2b. HOUR<br>5 A.M.                                                                              |                                                                           |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                               | 4 RACE<br>Caucasian                                                                                                                          | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>05 05 31                                                                                                              |                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.                                                       |                                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                                     | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |                                                                           |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                         |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                              | 13b. COUNTY<br>Anne Arundel                                                                                                                                | 13c. CITY OR TOWN<br>Pasadena                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>235 ARUNDEL RD.                                    |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Harthausen                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Belle Vernon                                                                                         |                                                                                |                                                                                                 |                                                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown                                                                                                                                                                                                                                                                                                                               |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>214 26 7857                                                                                                                    |                                                                                | 17 INFORMANT<br>John H. Treasure same as 13                                                     |                                                                           |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiogenic shock</u><br>3951<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>aortic insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>rheumatic heart disease</u> |                                                                                                                                              |                                                                                                                                                            |                                                                                |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hrs.<br>years<br>years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                           |                                                                                                                                              |                                                                                                                                                            |                                                                                |                                                                                                 |                                                                           |
| 19a. DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                                                      |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                           |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                           |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> , 19 <u>79</u> , to <u>June 25</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 25</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |                                                                                                                                              |                                                                                                                                                            |                                                                                |                                                                                                 |                                                                           |
| 22b. SIGNATURE<br>Dr. Marlene Jaro                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                              | DEGREE                                                                                                                                                     |                                                                                | 22c. DATE SIGNED<br>June 25, 1979                                                               |                                                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. MARLENE JARO                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 22e. ADDRESS<br>Univ. of Maryland Hospital or<br>3 Sulky Ct. #202, Randall Hospital                                                                        |                                                                                |                                                                                                 |                                                                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                        | 23b. DATE<br>01/20/1979                                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                                                                                                      |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pr. Anne Arund. Md.                      |                                                                           |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCurry F.N. Mountain & Lockwood Rds. Pa., Md.                                                                                                                                                                                                                                                                                                                                |                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                                                                                                               |                                                                                | 25b. REGISTRAR'S SIGNATURE<br>Fitzroy McBrody                                                   |                                                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                            |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | FIRST<br>LILA                                                                                                                                              | MIDDLE<br>TRIMPER                                                                                                                          | LAST<br>TRIMPER                                                                                                                      | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 13, 1979           | 2b HOUR<br>3:10 P.M.                                          |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                          | 4 RACE<br>Cauc.                                                                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 11 1915                                                                                                          | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.                                                                                                  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                    |                                                               | 7b IF UNDER 24 HRS<br>HOURS MIN.                              |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                     | 7d CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                            |                                                               |                                                               |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                    | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Business woman                                                          |                                                                                                                                      | 12b KIND OF BUSINESS OR INDUSTRY<br>Mgr. Apts. Amvs. Enterpr. |                                                               |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.                                                                                                                                                                                                                                                                                                                          | 13b COUNTY<br>Wor.                                                                                                                     | 13c CITY OR TOWN<br>OCEAN CITY                                                                                                                             | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                             | 13e STREET ADDRESS<br>West Ocean C. Ty, Md. 21842                                                                                    |                                                               |                                                               |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard J. Pending                                                                                                                                                                                                                                                                                                                                                                              | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lousia Busby                                                                           |                                                                                                                                                            | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                      |                                                                                                                                      |                                                               |                                                               |
| 16b SOCIAL SECURITY NO.<br>215-18-5496                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 17 INFORMANT<br>DANIEL TRIMPER III W. OCEAN CITY, MD.                                                                                                      |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4412<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>CARDIOGENIC SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>POSSIBLE MI DURING RESECTION OF THORACIC ANEURYSM</u><br>2 HRS |                                                                                                                                        |                                                                                                                                                            |                                                                                                                                            |                                                                                                                                      |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 min<br>1 HR |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                       |                                                                                                                                        |                                                                                                                                                            |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
| 19a DATE OF OPERATION<br>6/13                                                                                                                                                                                                                                                                                                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>THORACIC ANEURYSM                                                                   |                                                                                                                                                            | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                               |                                                               |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6/13</u> 19 <u>79</u> , to <u>6/13</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                              |                                                                                                                                        |                                                                                                                                                            |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
| 22b SIGNATURE<br>Karl Jon Karlson, MD                                                                                                                                                                                                                                                                                                                                                                                                    | DEGREE<br>MD                                                                                                                           |                                                                                                                                                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                      | 22c DATE SIGNED<br>6/13/79                                    |                                                               |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>KARL JON KARLSON                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                        | 22e ADDRESS<br>JOHNS HOPKINS HOSPITAL                                                                                                                      |                                                                                                                                            |                                                                                                                                      |                                                               |                                                               |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                       | 23b DATE<br>JUNE 16, 1979                                                                                                              | 23c NAME OF CEMETERY OR CREMATORY<br>EVERGREEN Cem.                                                                                                        |                                                                                                                                            | 23d LOCATION<br>CITY OR TOWN<br>BERLIN                                                                                               | COUNTY<br>Wor.                                                | STATE<br>MD.                                                  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Jean B. Prettymen                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                        | ADDRESS<br>108 Wilkin Berlin Md.                                                                                                                           |                                                                                                                                            | 25a DATE RECEIVED BY REGISTRAR<br>JUN 22 1979                                                                                        | 25b REGISTRAR'S SIGNATURE                                     |                                                               |

10/21/61





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14702

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                    |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH DAY YEAR                                                      |  | 2b. HOUR                                    |  |
| Doris V. Trott                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 06 30 79                                                                                                                                                 |  |                                                                     |  | A. M.                                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                          |  |
| Female                                                                                                                                                                                                                                                                                                                                                 |  | White                                                                                                  |  | Feb. 27, 1926                                                                                                                                            |  | 53 years                                                            |  | MONTHS DAYS HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                             |  |
| Maryland                                                                                                                                                                                                                                                                                                                                               |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | Baltimore City, MD                                                  |  |                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                             |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                              |  | 307 S. Pulaski Street                                                                                  |  | Homemaker                                                                                                                                                |  |                                                                     |  |                                             |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                         |  |
| Md.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | Baltimore                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 307 S. Pulaski Street                       |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT                               |  |
| Henry                                                                                                                                                                                                                                                                                                                                                  |  | Anna Hoffman                                                                                           |  | NO                                                                                                                                                       |  | 214-20-7990                                                         |  | Mrs. Donette M. Bangert, 2214 Parkside Ave. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- ACUTE CORONARY occlusion                                                                                                                                                                                                 |  | DUE TO, OR AS A CONSEQUENCE OF (b) Hyperkalemia                                                        |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  | minutes                                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | years                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                             |  |
|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                             |  |
|                                                                                                                                                                                                                                                                                                                                                        |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
|                                                                                                                                                                                                                                                                                                                                                        |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                            |  | CITY OR TOWN                                                        |  | COUNTY STATE                                |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | STREET                                                                                                                                                   |  |                                                                     |  |                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Years back</u> to <u>October</u> 19 <u>78</u> , that (I) (we) last saw the deceased alive on <u>Oct.</u> 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                         |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED                                                    |  |                                             |  |
| <u>Henry Armanas, M.D.</u>                                                                                                                                                                                                                                                                                                                             |  | M.D.                                                                                                   |  |                                                                                                                                                          |  | 7/4/2, 1979                                                         |  |                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
| Dr. Henry Armanas, M.D.                                                                                                                                                                                                                                                                                                                                |  | 2919 Hollins Ferry Road                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  | COUNTY STATE                                |  |
| Burial                                                                                                                                                                                                                                                                                                                                                 |  | 7/3/79                                                                                                 |  | Loudon Park Cemetery                                                                                                                                     |  | Baltimore City, Maryland                                            |  |                                             |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                              |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                             |  |
| Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                             |  | 4107 Wilkens Ave.                                                                                      |  | JUL 2 1979                                                                                                                                               |  | <u>[Signature]</u>                                                  |  |                                             |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 1 4 7 0 3

1 - FOR  
STATE  
REGISTRAR

|                                                                            |                                                                                                                                       |                                                                                                                                                            |                                                                                   |                                                                                                |                                                               |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MILES R. MIDDLE LAST TULL      |                                                                                                                                       |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>06 06 79                                    |                                                                                                | 2b HOUR<br>6:15 AM                                            |
| 3 SEX<br>MALE                                                              | 4 RACE<br>White                                                                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 03 26                                                                                                              |                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                                                      | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                       | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                               |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto General Hosp |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Crane Operator | 12b KIND OF BUSINESS OR INDUSTRY<br>Steel Co.                                                  |                                                               |
| 13a STATE<br>MD                                                            |                                                                                                                                       | 13b COUNTY                                                                                                                                                 | 13c CITY OR TOWN<br>BALTO                                                         | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>1208 WILLIAM ST.                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Roger C. TULL                    |                                                                                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie V. SMITH                                                                                             |                                                                                   |                                                                                                |                                                               |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |                                                                                                                                       | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 11                                                                                           | 17 INFORMANT ADDRESS<br>Mr. Bennard B. Bower, Jr. ?                               |                                                                                                |                                                               |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

|                                                                |                                                 |
|----------------------------------------------------------------|-------------------------------------------------|
| IMMEDIATE CAUSE (a)<br>2019 Pulmonary edema - Bronchopneumonia | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DOE TO, OR AS A CONSEQUENCE OF<br>(b) Hodgkin's Disease        |                                                 |
| DOE TO, OR AS A CONSEQUENCE OF<br>(c)                          |                                                 |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Generalized arteriosclerosis

|                                                                                                                                                                                                                                                                                                                         |                                                                       |                                                                                                                                                      |                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                             | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                        |                                                                                                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                             | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                     |                                                                                                                              |
| 22a I certify that (I) (this hospital) attended the deceased from 05120 19 79, to 06106 19 79, that (I) (we) lost<br>saw the deceased alive on 06106 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                       |                                                                                                                                                      |                                                                                                                              |
| 22b SIGNATURE<br>M. Fleischman                                                                                                                                                                                                                                                                                          |                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br>06/06/79                                                                                                  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. Fleischman                                                                                                                                                                                                                                                                   |                                                                       | 22e ADDRESS<br>South Balto General Hosp.                                                                                                             |                                                                                                                              |

|                                                                                          |                          |                                                           |                                                                             |
|------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                    | 23b DATE<br>June 9, 1979 | 23c NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Harrie, A.A. Co. Maryland |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. |                          | 25a DATE REC'D. BY REGISTRAR<br>JUN 8 1979                | 25b REGISTRAR'S SIGNATURE<br>[Signature]                                    |

C U I P I

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14704

|                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                  |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                                                |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                        |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                                                |
| RAYMOND Edward TURBUTT                                                                                                                                                                                                                                                                                                  |                                                                                                        | 6/10/79                                                                                                                                                  |                                                                     | 6 PM                                                                           |                                                                |
| 3. SEX                                                                                                                                                                                                                                                                                                                  | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                                                                | 7. IF UNDER 1 YEAR                                             |
| MALE                                                                                                                                                                                                                                                                                                                    | WHITE                                                                                                  | 10 17 17                                                                                                                                                 | 61                                                                  | MONTHS DAYS HOURS MIN.                                                         |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                |                                                                |
| Maryland                                                                                                                                                                                                                                                                                                                | USA                                                                                                    |                                                                                                                                                          | BALTIMORE CITY MD.                                                  |                                                                                |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                                                |                                                                |
| BALTIMORE                                                                                                                                                                                                                                                                                                               | SINAI HOSPITAL                                                                                         | DISABLED                                                                                                                                                 | Beth. Steel Heater                                                  |                                                                                |                                                                |
| 13a. STATE                                                                                                                                                                                                                                                                                                              | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |                                                                |
| MD                                                                                                                                                                                                                                                                                                                      | BALTIMORE                                                                                              | MALT.                                                                                                                                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4100N CHARLES ST.                                                              |                                                                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME                                                                               | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                         |                                                                     |                                                                                |                                                                |
| William Turbutt                                                                                                                                                                                                                                                                                                         | Mary Elizabeth Amey                                                                                    | No                                                                                                                                                       |                                                                     |                                                                                |                                                                |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                |                                                                                                        | 17. INFORMANT ADDRESS                                                                                                                                    |                                                                     |                                                                                |                                                                |
| 218-01-9677                                                                                                                                                                                                                                                                                                             |                                                                                                        | Charles St. Mrs. Margaret M. Turbutt, 4100 N.                                                                                                            |                                                                     |                                                                                |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| IMMEDIATE CAUSE (a) 1629 RESP ARREST                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL METASTASIS                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                |
|                                                                                                                                                                                                                                                                                                                         |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                                     |                                                                                |                                                                |
|                                                                                                                                                                                                                                                                                                                         |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                     |                                                                                |                                                                |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                    |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION                                                                  |                                                                |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     | STREET CITY OR TOWN COUNTY STATE                                               |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/8/79, 19 79, to 6/10, 19 79, that (I) (we) last saw the deceased alive on 6/10/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                          |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                               |                                                                |
| MARIS DAVIS                                                                                                                                                                                                                                                                                                             |                                                                                                        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |                                                                     | 6/10/79                                                                        |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                   |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                                |                                                                |
| MARIS DAVIS                                                                                                                                                                                                                                                                                                             |                                                                                                        | Sinai Hospital Balt Md                                                                                                                                   |                                                                     |                                                                                |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                               | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                     | 23d. LOCATION                                                                  |                                                                |
| Cremated                                                                                                                                                                                                                                                                                                                | 6/12/79                                                                                                | Westview Crematory                                                                                                                                       |                                                                     | Baltimore, Maryland                                                            |                                                                |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                    |                                                                                                        | 25. DATE REC'D BY REGISTRAR                                                                                                                              |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                                                                |
| J. E. Lowell Lemmon, 10 W. Padonia Rd.                                                                                                                                                                                                                                                                                  |                                                                                                        | JUN 12 1979                                                                                                                                              |                                                                     | [Signature]                                                                    |                                                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |  | REG. NO. 14705                                        |  |                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice C. Turner</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 29 79</b> |  | 2b. HOUR<br><b>630 P.M.</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Black</b>                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 13 13</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                                                                                                                                                                                                                                                                                                                  |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>YRS</b>           |  |                             |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                                         |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                       |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                             |  |                                                       |  |                             |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                                |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1141 Stockton St</b>                                                                                                                                                                                                                                                                                                                |  |                                                       |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Anderson</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Turner</b>                                                                                         |  |                                                                                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown</b>                                                                                                                                                                                                                                                                        |  |                                                       |  |                             |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-32-3717</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret Williams 628 King Ave</b>                                                                                           |  |                                                                                                 |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1749</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Malignant Metastatic Carcinoma of the breast.</b><br>(c) <b>1976</b> |  |                                                       |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                        |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                       |  |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                    |  |                                                       |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                       |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET<br><b>22. S. Greene St.</b>                                                                                                         |  | CITY OR TOWN<br><b>Baltimore</b>                                                                |  | COUNTY<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                          |  | STATE                                                 |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/22</b> 19 <b>79</b> to <b>6/29</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/29</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                       |  |                             |  |
| 22b. SIGNATURE<br><b>Keith N. Van Andelen</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                                    |  | 22c. DATE SIGNED<br><b>6/29/79</b>                    |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Keith N. Van Andelen</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  | 22e. ADDRESS<br><b>22. S. Greene St.</b>                                                                                                                    |  |                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                       |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>7/3/79</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>                                               |  | COUNTY<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                          |  | STATE                                                 |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                        |  |                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                                                                                                                                                                                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McBrady</b>  |  |                             |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | REG. NO. 14706                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) <del>TURNER</del> CARL J. TURNER                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | June 7, 1979                                                                                                            |  |
| 3. SEX M                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 4. RACE B                                                                                                               |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 5 21 04                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                        |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.                                                                    |  |
| 10. CITY OR TOWN OF DEATH Balto.                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOME             |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE Md                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 13b. COUNTY                                                                                                             |  |
| 13c. CITY OR TOWN Balto                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST FIELDING TURNER                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA GORDON                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 218-05-0188                                                                                    |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | ADDRESS same address                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 Septicemia from urinary tract infection                                                                                                                                     |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 multiple strokes and decubitus ulcer @ hip                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION 5/7/79                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Decubitus ulcer @ hip                                                  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                    |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                     |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7/79 2/23/69, to 6/7/79, that (I) (we) lost saw the deceased alive on 6/7/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                                                                                                         |  |
| 22b. SIGNATURE D. W. STEWART, M.D.                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 6/7/79                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. W. STEWART, M.D.                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 2300 Garrison Blvd.                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 23b. DATE 6-11-79                                                                                                       |  |
| 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.                                                                   |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D BY REGISTRAR JUN 11 1979                                                                                |  |
| 24. FUNERAL DIRECTOR ADDRESS 1101 E. North Ave.                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]                                                                                  |  |

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Theresa A. Turner</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 24 79</b>                                           |                                                                                     | 2b HOUR<br><b>1:10 A.M.</b>                                                                                                          |
| 3 SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br><b>B</b>                                                                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 2 66</b>                                                                                                        |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>12</b><br>YRS.                                 |                                                                                                                                      |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                                                                                                                      |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>student</b>              |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                                                                                      |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13b COUNTY                                                                                                                                 | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>324 N. Stricker St</b>                                     |                                                                                                                                      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lenvele Turner</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Christine Strong</b>                                                                                    |                                                                                                |                                                                                     |                                                                                                                                      |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 16b SOCIAL SECURITY NO.<br><b>none</b>                                                                                                                     | 17 INFORMANT ADDRESS<br><b>MR. LINVIL TURNER 324 N. STRICKER ST.</b>                           |                                                                                     |                                                                                                                                      |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br><b>1719</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>chondrosarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1719</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min</b><br><b>2 yr</b> |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Pt vomiting Blood</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                                      |
| 19a DATE OF OPERATION<br><b>none</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>                                                                                             |                                                                                                | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>P.M.</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                            | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                |                                                                                                | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                                      |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                      |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/22/79</b> to <b>6/24/79</b> , that (I) (we) last saw the deceased alive on <b>6/24/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                  |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                                     |                                                                                                                                      |
| 22b SIGNATURE<br><b>Dale Bradley Call MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                            |                                                                                                                                            |                                                                                                                                                            |                                                                                                |                                                                                     | 22c DATE SIGNED                                                                                                                      |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dale Bradley Call</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                            | 22e ADDRESS<br><b>22 S. Green St, Baltimore, Md</b>                                            |                                                                                     |                                                                                                                                      |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 23b DATE<br><b>6-27-79</b>                                                                                                                 | 23c NAME OF CEMETERY OR CREMATORY<br><b>KING Memorial Pk.</b>                                                                                              |                                                                                                | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. Md.</b>                      |                                                                                                                                      |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SAMUEL T. Redd 5209 YORK Rd. BALTO. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                            |                                                                                                                                                            | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                             |                                                                                     | 25b REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>                                                                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10141 21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                               |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                     |                                                                                                                                                          | 2a. DATE OF DEATH                                                                                                                          |                                                                                |                                      |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          | MONTH DAY YEAR                                                                                                                             |                                                                                |                                      |                                                                |                                              |
| George W. Tuttle                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     |                                                                                                                                                          | 06 05 79                                                                                                                                   |                                                                                |                                      |                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                                                |                                                                     | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                            |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                                                | 7b. HOUR                                     |
| MALE                                                                                                                                                                                                                                                                                                               |  | N                                                                                                      |                                                                     | 02 09 07                                                                                                                                                 |                                                                                                                                            |                                                                                | 72                                   |                                                                | 11.00 P.M.                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY            |
| N.C.                                                                                                                                                                                                                                                                                                               |  | U.S.                                                                                                   |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                | Baltimore city MD                    |                                                                | STEEL                                        |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |                                                                                |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                          |  | South Balto. General                                                                                   |                                                                     |                                                                                                                                                          | Retired welder                                                                                                                             |                                                                                |                                      | STEEL                                                          |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                            |                                                                     | 13c. CITY OR TOWN                                                                                                                                        |                                                                                                                                            | 13d. INSIDE CITY LIMITS?                                                       |                                      | 13e. STREET ADDRESS                                            |                                              |
| MD                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                     | Balto                                                                                                                                                    |                                                                                                                                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                      | 2723 Carver Road.                                              |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                                                                                                   |                                                                                |                                      |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          | FIRST MIDDLE LAST                                                                                                                          |                                                                                |                                      |                                                                |                                              |
| WALLACE TUTTLE                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                     |                                                                                                                                                          | ANNIE UNKNOWN                                                                                                                              |                                                                                |                                      |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                                                                                                                   |                                                                                | 17. INFORMANT ADDRESS                |                                                                |                                              |
| NO                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                     |                                                                                                                                                          | 244-07-6927                                                                                                                                |                                                                                | Pella Mac Brooks 2722 Carver Rd.     |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Pulmonary edema + congestion                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| 515- DUE TO, OR AS A CONSEQUENCE OF (b) Massive pulmonary fibrosis                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                 |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| Diabetes - Generalized arteriosclerosis                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                                                                                                                            | 20a. AUTOPSY?                                                                  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  |                                                                                                        | 21b. TIME OF INJURY                                                 |                                                                                                                                                          |                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                      |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                            |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        | P.M. 19                                                             |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                               |  |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          |                                                                                                                                            | 21f. LOCATION                                                                  |                                      |                                                                |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            | STREET CITY OR TOWN COUNTY STATE                                               |                                      |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 05/25, 1979, to 06/05, 1979, that (I) (we) lost saw the deceased alive on 06/05, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                                                |                                      |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                     |                                                                                                                                                          | DEGREE                                                                                                                                     |                                                                                |                                      | 22c. DATE SIGNED                                               |                                              |
| M. Fleischman                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                     |                                                                                                                                                          | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                |                                      | 06/05/79.                                                      |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          | 22e. ADDRESS                                                                                                                               |                                                                                |                                      |                                                                |                                              |
| M. Fleischman                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                     |                                                                                                                                                          | South Balto. General Hosp.                                                                                                                 |                                                                                |                                      |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                              |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                                                                            | 23d. LOCATION                                                                  |                                      | 23e. STATE                                                     |                                              |
| Burial                                                                                                                                                                                                                                                                                                             |  | 6-11-79                                                                                                |                                                                     | Cedar Hill CEMET.                                                                                                                                        |                                                                                                                                            | Baltimore                                                                      |                                      | Md                                                             |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                          |  |                                                                                                        |                                                                     |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                                                                | 25b. REGISTRAR'S SIGNATURE           |                                                                |                                              |
| Leroy O. Dyett AND SON                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                     |                                                                                                                                                          | 4600 Liberty HT JUN 7 1979                                                                                                                 |                                                                                | Pella Mac Brooks                     |                                                                |                                              |

00111 PA

UNITED STATES





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed in the funeral home with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

TYSON ERICA  
04 11 1979

|                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Erica Lynn Tyson</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 16, 1979</b>                                     |                                                                                      | 2b. HOUR<br>MIN<br><b>12:47<sup>a</sup></b> |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><b>Black</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 11 1979</b>                                                                                                      |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN<br><b>2 5</b>          |                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |                                             |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>md BALTO.</b>                                                                                                                                                                                                                        |                                                                                                                                                 |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Tyson</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                 |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julvette Price</b>                          |                                                                                      |                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                                                 | 17. INFORMANT ADDRESS<br><b>Julvette Price 1807 Karow Ct.</b>                        |                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest.</b><br><b>3302</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Group B Streptococcal Meningitis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>304 hrs.</b> |                                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>                                                                                                                                                                                                                                  |                                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                             |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                                                                                                |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                             |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                           |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/14/79</b> , 19____, to <b>6/16/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>12:46 AM 6/16/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |                                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                             |
| 22b. SIGNATURE<br><b>G. A. Taylor M.D.</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                 | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>6/16/79.</b>                                                  |                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George A. Taylor.</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                 | 22e. ADDRESS<br><b>Johns Hopkins Hospital.</b>                                                                                                              |                                                                                                 |                                                                                      |                                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                          | 23b. DATE<br><b>6-20-79</b>                                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kings Mem. Pk.</b>                                                                                                 |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Md.</b>                |                                             |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Isaiah L. Brown &amp; Son PA 1913 W. Balto. St.</b>                                                                                                                                                                                                                                                                                      |                                                                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>H. McCreedy</b>                                     |                                             |

Figure 1 consists of seven sequential black and white micrographs arranged horizontally, showing the development of an embryo. From left to right: 1. A single, small, dark, rounded cell. 2. A cell with a slightly more defined, irregular shape. 3. A cell showing internal granular structure. 4. A cell with a more elongated and segmented appearance. 5. A cell with a distinct, elongated, and segmented body. 6. A cell with a more complex, segmented structure, possibly showing the beginning of a tail. 7. A cell with a well-defined, elongated, and segmented body, resembling a small larva or a more advanced embryo stage.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14710

|                                                                                                                                                                                                                                                                                                                                                                       |                                        |                                                                                                                                                             |  |                                                                                             |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ADELE C ULRICH                                                                                                                                                                                                                                                                                                                 |                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 22 79                                                                                                             |  | 2b. HOUR<br>10 26am                                                                         |                                                 |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>Caucasian                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 03 1905                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                                   |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                  |                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                |                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GEN. HOSP                      |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>At. Production Mfg. Co. |                                                 |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                      |                                        | 13b. COUNTY<br>A.A.                                                                                                                                         |  | 13c. CITY OR TOWN<br>ARNOLD                                                                 |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWIN A. SEIDEWITZ                                                                                                                                                                                                                                                                                                          |                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ADELE W. WATENSCHIED                                                                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                  |                                                 |
| 16b. SOCIAL SECURITY NO.<br>215 053077                                                                                                                                                                                                                                                                                                                                |                                        | 17. INFORMANT<br>PATIENT                                                                                                                                    |  | ADDRESS<br>AS ABOVE                                                                         |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SEVERE ARTERIO SCLEROSIS</u>                                   |                                        |                                                                                                                                                             |  |                                                                                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                   |                                        |                                                                                                                                                             |  |                                                                                             |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |                                                 |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                              |                                        |                                                                                                                                                             |  |                                                                                             |                                                 |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                           |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>06-22</u> 19 <u>79</u> , to <u>06-22</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>06-22</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                        |                                                                                                                                                             |  |                                                                                             |                                                 |
| 22b. SIGNATURE<br><i>Henry</i>                                                                                                                                                                                                                                                                                                                                        |                                        | DEGREE                                                                                                                                                      |  | 22c. DATE SIGNED<br>06-22-79                                                                |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. AREM                                                                                                                                                                                                                                                                                                                      |                                        | 22e. ADDRESS<br>South Baltimore General Hosp.                                                                                                               |  |                                                                                             |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                |                                        | 23b. DATE<br>6.25.79                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>London Park Cem.                                      |                                                 |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore City MD                                                                                                                                                                                                                                                                                                                    |                                        | 23e. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                                |  |                                                                                             |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>BARRANKO E.H.                                                                                                                                                                                                                                                                                                                         |                                        | 25. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                                 |  |                                                                                             |                                                 |

101141



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

14711

|                                                                                                                                             |                               |                                              |                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------|------------------------------------------------------|
| 1. STATE REGISTRAR                                                                                                                          |                               | FOR                                          |                                                      |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                         |                               | 2. DATE KNOWN OF DEATH                       |                                                      |
| Mary Underdok                                                                                                                               |                               | DATE KNOWN OF DEATH: MONTH 6 DAY 6 YEAR 1979 |                                                      |
| 3. SEX                                                                                                                                      | 4. RACE                       | 5. DATE OF BIRTH                             | 6. AGE (IN YEARS)                                    |
| female                                                                                                                                      | white                         | 11/6/1906                                    | 72 YRS                                               |
| 7. BIRTHPLACE                                                                                                                               | 8. CITIZEN OF WHAT COUNTRY?   | 9. BALTIMORE CITY OR COUNTY OF DEATH         | 10. CITY OR TOWN OF DEATH                            |
| Ind.                                                                                                                                        | U.S.A.                        | Baltimore City                               | Baltimore                                            |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                    | 12. USUAL OCCUPATION          | 13. STREET ADDRESS                           | 14. FATHER'S NAME                                    |
| Bon Secour Hospital                                                                                                                         | Housewife                     | 1612 Hollins St.                             | Joseph                                               |
| 15. MOTHER'S MAIDEN NAME                                                                                                                    | 16. SOCIAL SECURITY NO.       | 17. INFORMANT                                | 18. CAUSE OF DEATH                                   |
| Elizabeth                                                                                                                                   | 214-26-4140A                  | B. Dorothy Stewart                           | Hypertensive arteriosclerotic cardiovascular disease |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).         |                               |                                              |                                                      |
| 19a. DATE OF OPERATION                                                                                                                      |                               |                                              |                                                      |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                           |                               |                                              |                                                      |
| 20a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                                                           |                               |                                              |                                                      |
| 20b. TIME OF INJURY                                                                                                                         |                               |                                              |                                                      |
| 20c. HOW INJURY OCCURRED                                                                                                                    |                               |                                              |                                                      |
| 21a. INJURY OCCURRED                                                                                                                        |                               |                                              |                                                      |
| 21b. PLACE OF INJURY                                                                                                                        |                               |                                              |                                                      |
| 21c. LOCATION                                                                                                                               |                               |                                              |                                                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: |                               |                                              |                                                      |
| Natural causes Accident Suicide Homicide Undetermined manner                                                                                |                               |                                              |                                                      |
| ACTUAL SIGNATURE: Virginia L. Dolan M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 6/7/79                                    |                               |                                              |                                                      |
| EXAMINER'S NAME (TYPE OR PRINT): Virginia L. Dolan, M.D. ADDRESS: 111 Penn Street, Balto., MD 21201                                         |                               |                                              |                                                      |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                             | 23b. DATE                     | 23c. NAME OF CEMETERY OR CREMATORY           | 23d. LOCATION                                        |
| Burial                                                                                                                                      | 6/9/79                        | New Cathedral Cem.                           | Baltimore                                            |
| 24. FUNERAL DIRECTOR                                                                                                                        | 25a. DATE REC'D. BY REGISTRAR |                                              | 25b. REGISTRAR'S SIGNATURE                           |
| John J. Cowan, Inc.                                                                                                                         | JUN 12 1979                   |                                              | Anthony A. Brady                                     |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH-17  
1VR A15 ME (51)  
15M 7/76

1903

11/11/11



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14712

|                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              |                                                                                                                                                            |                                                                                   |                                                                                                              |                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRY NICHOLAS UNGUREIT</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-6-79</b>                                                                                                        |                                                                                   | 2b HOUR<br><b>8:10A</b>                                                                                      |                                                            |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                    | 4 RACE<br><b>WHITE</b>                                                                                                                       | 5 DATE OF BIRTH<br><b>MARCH 30, 1908</b>                                                                                                                   |                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                                              |                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br><b>WILKES BARRE, PA.</b>                                                                                                                                                                                                                                                                                            | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                                            |                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITALS</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |                                                                                                              | 12b KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL CO.</b> |
| 13a STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | 13b COUNTY<br><b>-----</b>                                                                                                                                 | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                              | 13d INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |                                                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHRISTOPHER UNGUREIT</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                              |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH ?</b>                |                                                                                                              |                                                            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                        |                                                                                                                                              | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>192-07-8680</b>                                                                                |                                                                                   | 17 INFORMANT<br>ADDRESS<br><b>CARRIE N. UNGUREIT ; 336 S. OLDHAM ST. BALTO., 21224, MD.</b>                  |                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DISSECTING ABDOMINAL AORTIC</b><br><b>4410</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ATHEROSCLEROTIC VASCULAR ANEURYSM</b><br>(c) <b>DISEASE</b> |                                                                                                                                              |                                                                                                                                                            |                                                                                   |                                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>HYPERTENSION, CONT</b>                                                                                                                                                                                       |                                                                                                                                              |                                                                                                                                                            |                                                                                   |                                                                                                              |                                                            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a AUTOPSY<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>             |                                                            |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |                                                                                                                                              | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                |                                                            |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             |                                                                                                                                              | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                            |                                                            |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/6</b> 19 <b>79</b> , to <b>6/6</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/6</b> 19 <b>79</b> , and that in my (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (old) did not view the body after death.    |                                                                                                                                              |                                                                                                                                                            |                                                                                   |                                                                                                              |                                                            |
| 22b SIGNATURE<br><b>VICTOR G. VOGEL, MD</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                              | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                                   | 22c. DATE SIGNED<br><b>6/6/79</b>                                                                            |                                                            |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VICTOR VOGEL, MD</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 22e ADDRESS<br><b>4940 EASTERN AVE, BALT 21224</b>                                                                                                         |                                                                                   |                                                                                                              |                                                            |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                              | 23b DATE<br><b>6-9-79</b>                                                                                                                                  |                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>                                               |                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>7225 EASTERN BLVD. BA. CO., MD.</b>                                                                                                                                                                                                                                                                    |                                                                                                                                              | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                                                                                                         |                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                                                         |                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Geiler &amp; Son, Inc.</b>                                                                                                                                                                                                                                                                                |                                                                                                                                              | 6224 EASTERN AVE.<br><b>BALTO., 21224, MD.</b>                                                                                                             |                                                                                   |                                                                                                              |                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1912



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 14713

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |                                                      |                                                                                                |                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WALTER H. VEASEL</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                             | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 19 79</b> |                                                                                                | 2b HOUR<br><b>7:30 AM</b> |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE<br><b>WHITE</b>                                                                                                                                      |                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 23 88</b>                                           |                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                                                                                                                                                                                                                                                                                                  |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                 |                                                      | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                   |                           |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                           |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                                                                             |                                                      |                                                                                                |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b>                 |                                                      | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b>         |                           |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                |  | 13a STATE<br><b>MARYLAND</b>                                                                                                                                |                                                      |                                                                                                |                           |  |
| 13b COUNTY                                                                                                                                                                                                                                                                                                                                                        |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                        |                                                      | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           |  |
| 13e STREET ADDRESS<br><b>730 GRANTLEY STREET, 21229</b>                                                                                                                                                                                                                                                                                                           |  | 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE W. VEASEL</b>                                                                                            |                                                      |                                                                                                |                           |  |
| 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA STAHL</b>                                                                                                                                                                                                                                                                                                 |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                |                                                      |                                                                                                |                           |  |
| 16b SOCIAL SECURITY NO.<br><b>219-10-1736</b>                                                                                                                                                                                                                                                                                                                     |  | 17 INFORMANT<br>ADDRESS<br><b>NELLIE KETTERMAN, 1901 CLIFTON ROAD, 21228</b>                                                                                |                                                      |                                                                                                |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>X</b>  |  |                                                                                                                                                             |                                                      |                                                                                                |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                  |  |                                                                                                                                                             |                                                      |                                                                                                |                           |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |                                                      | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                        |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)        |                                                      |                                                                                                |                           |  |
| 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                               |                                                      |                                                                                                |                           |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       |                                                      | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-5</b> , 19 <b>79</b> , to <b>6-18</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                             |                                                      |                                                                                                |                           |  |
| 22b SIGNATURE<br><b>R. Chen-Tan</b>                                                                                                                                                                                                                                                                                                                               |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                      | 22c. DATE SIGNED                                                                               |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. CHEN-TAN</b>                                                                                                                                                                                                                                                                                                       |  | 22e ADDRESS<br><b>Baltimore City Hospital</b>                                                                                                               |                                                      |                                                                                                |                           |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                         |  | 23b DATE<br><b>06-22-79</b>                                                                                                                                 |                                                      | 23c NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                                        |                           |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                                                                                                                                                                                                                                                                                       |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE. 21229</b>                                                          |                                                      |                                                                                                |                           |  |
| 25a DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                      |  | 25b REGISTRAR'S SIGNATURE<br><b>Jun 20 1979</b>                                                                                                             |                                                      |                                                                                                |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01141 88





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 1 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                          |                                                                                                                                                            |                                                                                       |                                                                                                                |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ADDIE BELL VENEY</b>                                                                                                                                                                                                                                                                          |                                                                                                                                          |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-1-79</b>                                  |                                                                                                                | 2b. HOUR<br>M<br><b></b>                                                                                                   |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br><b>BLACK</b>                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 16, 1910</b>                                                                                                |                                                                                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Richmond, Va.</b>                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                          | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                       | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                                              |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b> |                                                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>                                                                               |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | 13b. COUNTY<br><b></b>                                                                                                                                     | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                | 13e. STREET ADDRESS<br><b>316 N. Stricker Street</b>                                                                       |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Baylor Phillips</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Castle</b>                                                                                       |                                                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b> |                                                                                                                            |
| 16b. SOCIAL SECURITY NO.<br><b>219-07-2348</b>                                                                                                                                                                                                                                                                                                               |                                                                                                                                          | 17 INFORMANT<br><b>Mrs. Martha Veney</b>                                                                                                                   |                                                                                       | ADDRESS<br><b>316 N. Stricker Street</b>                                                                       |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>MYOCARDIAL INFARCTS ACUTE X2</b><br>(c) <b>ASCVD</b>                         |                                                                                                                                          |                                                                                                                                                            |                                                                                       |                                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b>                                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                          |                                                                                                                                          |                                                                                                                                                            |                                                                                       |                                                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION<br><b></b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>                                                                                                |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b></b> P.M. <b>19</b>                                                                                  |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>                                                                          |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                                                   |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5 28</b> 19 <b>79</b> , to <b>05 31</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>05 31</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                                                          |                                                                                                                                                            |                                                                                       |                                                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><b>E. ROME RO</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                          | 22c. DATE SIGNED<br><b>06 04 79</b>                                                                                                                        |                                                                                       | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. ROME RO</b>                                                     |                                                                                                                            |
| 22e. ADDRESS<br><b>1701 W. PRATT ST. BALTO MD</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                          | 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. ROME RO</b>                                                                                                 |                                                                                       | 22g. ADDRESS<br><b>1701 W. PRATT ST. BALTO MD</b>                                                              |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                          | 23b. DATE<br><b>6/5/79</b>                                                                                                                                 |                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MEMORIAL PARK</b>                                                |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN, MARYLAND</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                          | 24 FUNERAL DIRECTOR<br>NAME<br><b>LEROY D. DYETT</b>                                                                                                       |                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1979</b>                                                             |                                                                                                                            |
| 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McCreedy</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                          | 25c. REGISTRAR'S SIGNATURE<br><b></b>                                                                                                                      |                                                                                       | 25d. REGISTRAR'S SIGNATURE<br><b></b>                                                                          |                                                                                                                            |

11111

HOLIE KEE V. N. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                            |                                                                                      |                                              |                                                                                                                            | REG. NO. 79 14715 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HAROLD MAYO VICK                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 1, 1979                                             |                                                                            |                                                                                      | 2b. HOUR<br>11:05A                           |                                                                                                                            |                   |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>WHITE                                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 20 1908                                                                                                           |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                  |                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |                                                                                                                            |                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                 |                                                                                      |                                              |                                                                                                                            |                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                        |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LAWYER |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETIRED |                                                                                                                            |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                            | 13e. STREET ADDRESS<br>501 S. ROLLING RD.                                            |                                              |                                                                                                                            |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MAYO VICK                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELEANOR MCCAGHEY                               |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II 705-05-6725                                                            |                                                                        | 17. INFORMANT<br>MARJORIE K. VICK                                                                                                                           |                                                                                                 |                                                                            | 17. ADDRESS<br>SAME                                                                  |                                              |                                                                                                                            |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Renal failure<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) arteriosclerotic cardiovascular dis.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks<br>3-4 mos. |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes mellitus                                                                                                                                                                                                                     |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                 |                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/18 19 79 to 6/1 19 79, that (I) (we) lost<br>saw the deceased alive on 6/1 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                                                            |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| 22b. SIGNATURE<br>Nancy V. Strahan M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                              |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                            |                                                                                      | 22c. DATE SIGNED<br>6/1/79                   |                                                                                                                            |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NANCY V. STRAHAN                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL 21205                                                    |                                                                            |                                                                                      |                                              |                                                                                                                            |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>BURIAL                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         | 23b. DATE<br>6-4-79                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. MICHAELS                                              |                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HOWARD 6 MD.                           |                                              |                                                                                                                            |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FARLEY F.H.                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 24. ADDRESS<br>6601 FRED. AVE.                                                                  |                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                          |                                              | 25b. REGISTRAR'S SIGNATURE<br>Hickory McElroy                                                                              |                   |  |

CHAPTER IV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 7 1 6

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BERTHA M.ay VIERS</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 18, 1979</b>                                     |                                                                                      | 2b. HOUR<br><b>4:34 P.M.</b>                                                                                                  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>Caucasian</b>                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 28 1911</b>                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>68</b>                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Pasadena</b>                                                                                                                                                                |                                                                                                                                                |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS<br><b>204 th St. &amp; East Shore Rd.</b>                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Reed</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie White</b>                                                                                        |                                                                                                 |                                                                                      |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                      |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>214-26-4166</b>                                                                                                              |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>Larkin J. Viers same as 13</b>                        |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio-pulm Arrest</b><br><b>4/49</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acidosis hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>severe CHF ischemic heart disease</b>                        |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>90 min</b><br><b>4 hrs</b><br><b>y 3</b>                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                            |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/1/79</b> 19 <b>79</b> , to <b>6/18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/12/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><b>Peter Rock</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>         |                                                                                                 | 22c. DATE SIGNED<br><b>6/18/79</b>                                                   |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Rock</b>                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                               |                                                                                                 |                                                                                      |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 23b. DATE<br><b>6/21/1979</b>                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                               |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b>                                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mc Cully F. H. Mountian &amp; Tick Neck Rds. Pas. Md.</b>                                                                                                                                                                                                                                                           |                                                                                                                                                | ADDRESS<br><b>21122</b>                                                                                                                                     |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Larkin J. Viers</b>                                                                          |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. High priority be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |                                                            |                                                                                                                                                            |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>(Baby Boy) Charles K. Viney</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 3, 1979</b> |                                                                                                                                                            |                                                                         | 2b. HOUR<br><b>1:57a</b>                                                                                                              |  |                                                                                                                                       |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>White</b>                                                                                                                         |                                                            | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 29, 1979</b>                                                                                                   |                                                                         | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS HOURS MIN<br><b>4</b>                                                               |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS                                                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                            | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                         | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                                                       |  |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |                                                            |                                                                                                                                                            |                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>--</b>                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>                                                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |                                                            |                                                                                                                                                            |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 13a. STATE<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>Mineral</b>                                                                                                                  |                                                            | 13c. CITY OR TOWN<br><b>Keyser</b>                                                                                                                         |                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>559 Va. St.</b>                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles K. Hickey</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |                                                            |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joyce Ann Viney</b> |                                                                                                                                       |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>                                                                           |                                                            | 17. INFORMANT ADDRESS<br><b>Joyce A. Viney 559 Va. Keyser, W. Va.</b>                                                                                      |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>769-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hyaline Membrane Disease, Renal Failure</b> |  |                                                                                                                                                |                                                            |                                                                                                                                                            |                                                                         |                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>None</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |                                                            |                                                                                                                                                            |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>                                                                                |                                                            |                                                                                                                                                            |                                                                         | 19c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |                                                            | 21c. HOW INJURY OCCURRED<br>NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2<br><b>None</b>                                                                   |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/31</b> , 19 <b>79</b> , to <b>6/3</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                       |  |                                                                                                                                                |                                                            |                                                                                                                                                            |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Barry Lerman M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |                                                            | DEGREE<br><b>Resident</b>                                                                                                                                  |                                                                         |                                                                                                                                       |  | 22c. DATE SIGNED<br><b>6/3/79</b>                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARRY LERMAN M.D.</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |                                                            | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                              |                                                                         |                                                                                                                                       |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>6 June 79</b>                                                                                                                  |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Potomac Mem. Gardens</b>                                                                                          |                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Keyser Mineral W. Va.</b>                                                            |  |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Allen M. Rotruck Keyser, W. Va.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |                                                            | 25a. DATE OF DEATH BY REGISTRATION<br><b>JUN 7 1979</b>                                                                                                    |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                      |  |                                                                                                                                       |  |



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(New York) Charles H.

May 22, 1932

Wife

Male

U.S.A.

London

The Journal of the Royal Society

Baltimore

222 No. 22

W

Robert

General

W. Va.

Viney

Wm

Robert

Wickley

W.

Charles

Robert A. Viney 222 No. 22, Robert, W. Va.

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W.

11 11 11

Robert A. Viney 222 No. 22, Robert, W. Va.





FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14718

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES B. VINKEMULDER</b>                                                                                                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 27, 1979</b>                                     |                                                                                      | 2b. HOUR<br><b>10:55A</b>                                                           |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><b>caucasian</b>                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 8, 1931</b>                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>47</b>                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |                                                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>analyst</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>financial</b>                                |                                                                                     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Talbot Easton</b>                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Brookwood Avenue</b>                                       |                                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry B. Vinkemuler</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Harriet Chatfield</b>                       |                                                                                      |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                 |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>Korea</b>                                                                                                                    |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>Janel M. Hull 49 Lincoln St. Belmont, Mass.</b>       |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>septic shock</b><br><b>5716</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ascites</b>                                                                             |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1-2 days</b><br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>portal hypertension due to cirrhosis due to sclerosing cholangitis + u.c.</b>                                                                                                                                            |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79                                                                                               |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/27</b> , 19 <b>79</b> , to <b>6/27</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                     |
| 22b. SIGNATURE<br><b>Stephen Wank</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | DEGREE<br><b>Wank</b>                                                                                                                                       |                                                                                                 | 22c. DATE SIGNED<br><b>6/27/79</b>                                                   |                                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen Wank</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 22e. ADDRESS<br><b>550 N. Broadway, Balt. Md., 21205</b>                                                                                                    |                                                                                                 |                                                                                      |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | 23b. DATE<br><b>6-30-1979</b>                                                                                                                               |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Delmarva Crematory</b>                      |                                                                                     |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lewes, Sussex, Delaware</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 24. FUNERAL DIRECTOR<br>NAME<br><b>Newnam Funeral Home Easton, Md.</b>                                                                                      |                                                                                                 |                                                                                      |                                                                                     |
| 25a. RECEIVED BY REGISTRAR<br><b>JUL 5 1979</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony K. Brady</b>                                                                                                       |                                                                                                 |                                                                                      |                                                                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial transit permit. Then please remove your portion and file it in the folder provided for filing within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or any other condition, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 1 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                            |                                                                                                |                                                                               |                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ADAM VOELKER JR.</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br><b>6-2-1979</b>                                             |                                                                               | 2b HOUR<br><b>M</b>                                                                                                       |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                             | 4 RACE<br><b>WHITE</b>                                                                                                                  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 16 1903</b>                                                                                                      |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS                               |                                                                                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                           | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD               |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>700 S. ELLWOOD AVE.</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |                                                                               | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                          | 13b COUNTY<br><b>BALTIMORE</b>                                                                                                          | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>700 S. ELLWOOD AVE</b>                               |                                                                                                                           |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ADAM VOELKER JR</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY VOLKER</b>                                                                                         |                                                                                                |                                                                               |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                         | 16b SOCIAL SECURITY NO.<br><b>216 01 1561A</b>                                                                                                             |                                                                                                | 17 INFORMANT ADDRESS<br><b>MARIE E. VOELKER SAME</b>                          |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma of the Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>with Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                         |                                                                                                                                                            |                                                                                                |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                |                                                                                                                                         |                                                                                                                                                            |                                                                                                |                                                                               |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |                                                                                                                                         | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                                | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6-1-</b> 19 <b>79</b> to <b>6/2</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                    |                                                                                                                                         |                                                                                                                                                            |                                                                                                |                                                                               |                                                                                                                           |
| 22b SIGNATURE<br><b>Dr. J. E. Evans MD</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                                                | 22c DATE SIGNED<br><b>6/4/79</b>                                              |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BAYANI B. ELMA MD</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 22e ADDRESS<br><b>3023 EASTERN AVE Balt. Md 21224</b>                                                                                                      |                                                                                                |                                                                               |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                               | 23b DATE<br><b>6-5-1979</b>                                                                                                             | 23c NAME OF CEMETERY OR CREMATORY<br><b>OAKLAWN CEM</b>                                                                                                    |                                                                                                | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>              |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HOFFMANN FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         | ADDRESS<br><b>HUDSON ST</b>                                                                                                                                |                                                                                                | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                             | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. TO STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14720

|                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                     |        |                                                                                                                                                          |                                                                                                      |                                                                     |                                           |                                         |                          |                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------|-----------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                     |         | FIRST                                                                                               | MIDDLE | LAST                                                                                                                                                     | 2a. DATE KNOWN OF DEATH ESTI- MATED                                                                  |                                                                     | MONTH                                     | DAY                                     | YEAR                     | 2b. HOUR                                                                                      |
| LARRY G. WADSWORTH                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                     |        |                                                                                                                                                          | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |                                                                     | 6                                         | 23                                      | 1979                     | 9:21 AM                                                                                       |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE | 5. DATE OF BIRTH                                                                                    |        | 6. AGE (IN YEARS)                                                                                                                                        | 7. IF UNDER 1 YR.                                                                                    |                                                                     | 8. IF UNDER 24 HRS.                       |                                         | 2c. DATE PRONOUNCED DEAD |                                                                                               |
| male                                                                                                                                                                                                                                                                                                                                                                                                                    | white   | Jan. 11, 1941                                                                                       |        | 38 YRS.                                                                                                                                                  | MONTHS                                                                                               |                                                                     | DAYS                                      | HOURS                                   | MIN.                     | 6 23 1979                                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                               |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                        |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                           |                                         |                          |                                                                                               |
| Loydell, Penna.                                                                                                                                                                                                                                                                                                                                                                                                         |         | U.S.A.                                                                                              |        | Baltimore City                                                                                                                                           |                                                                                                      |                                                                     |                                           |                                         | MD.                      |                                                                                               |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                               |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) |        |                                                                                                                                                          |                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                           | 12b. KIND OF BUSINESS OR INDUSTRY       |                          |                                                                                               |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                               |         | City Hospital                                                                                       |        |                                                                                                                                                          |                                                                                                      | Assembly Line                                                       |                                           | Chevrolet                               |                          |                                                                                               |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                              |         | 13b. COUNTY                                                                                         |        | 13c. CITY OR TOWN                                                                                                                                        |                                                                                                      | 13d. INSIDE CITY LIMITS?                                            |                                           | 13e. STREET ADDRESS                     |                          |                                                                                               |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                     |        | Baltimore                                                                                                                                                |                                                                                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                           | 502 S. Glover Street                    |                          |                                                                                               |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                       |         | 15. MOTHER'S MAIDEN NAME                                                                            |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |                                                                                                      | 16b. SOCIAL SECURITY NO.                                            |                                           | 17. INFORMANT ADDRESS                   |                          |                                                                                               |
| Wayne                                                                                                                                                                                                                                                                                                                                                                                                                   |         | Jennie                                                                                              |        | No                                                                                                                                                       |                                                                                                      | 217-38-0540                                                         |                                           | Mrs. Jennie Wadsworth 502 S. Glover St. |                          |                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |         |                                                                                                     |        |                                                                                                                                                          |                                                                                                      |                                                                     |                                           |                                         |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                   |        |                                                                                                                                                          |                                                                                                      |                                                                     |                                           |                                         |                          | 20. AUTOPSY?<br>BODY ONLY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                     |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                          |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                                                      |                                                                     |                                           |                                         |                          |                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                         |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                                                      |                                                                     |                                           |                                         |                          |                                                                                               |
| 22a. I certify that I took charge of the remains described above and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                            |         |                                                                                                     |        |                                                                                                                                                          |                                                                                                      |                                                                     |                                           |                                         |                          |                                                                                               |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                        |         | TITLE (SPECIFY)                                                                                     |        |                                                                                                                                                          |                                                                                                      | DATE SIGNED                                                         |                                           |                                         |                          |                                                                                               |
| Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                                   |         | Assistant                                                                                           |        |                                                                                                                                                          |                                                                                                      | 6/23/79                                                             |                                           |                                         |                          |                                                                                               |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                         |         | ADDRESS                                                                                             |        |                                                                                                                                                          |                                                                                                      |                                                                     |                                           |                                         |                          |                                                                                               |
| Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                                   |         | 111 Penn Street                                                                                     |        |                                                                                                                                                          |                                                                                                      |                                                                     |                                           |                                         |                          |                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                               |         | 23b. DATE                                                                                           |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                                      |                                                                     | 23d. LOCATION (CITY OR TOWN COUNTY STATE) |                                         |                          |                                                                                               |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                  |         | 6-26-1979                                                                                           |        | Loudon Park Cemetery                                                                                                                                     |                                                                                                      |                                                                     | Baltimore, Maryland                       |                                         |                          |                                                                                               |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                    |         | 25a. DATE REC'D. BY REGISTRAR                                                                       |        |                                                                                                                                                          |                                                                                                      | 25b. REGISTRAR'S SIGNATURE                                          |                                           |                                         |                          |                                                                                               |
| Lilly & Zeiler Inc. 1901-07 Eastern Avenue                                                                                                                                                                                                                                                                                                                                                                              |         | JUN 25 1979                                                                                         |        |                                                                                                                                                          |                                                                                                      | [Signature]                                                         |                                           |                                         |                          |                                                                                               |

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Wm & S. Wm

Wm & S. Wm

Wm & S. Wm



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14721

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                             |                                                                                                                                                             |                                     |                                                                                                                                 |  |                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JACOB (JACK) WAGMAN</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 28, 1979</b> |                                                                                                                                                             | 2b. HOUR<br>MIN<br><b>5:17 A.M.</b> |                                                                                                                                 |  |                                                                |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>WHITE</b>                                                                                                            |                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 31, 1905</b>                                                                                                  |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>73</b>                                                                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                               |  |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |                                                             |                                                                                                                                                             |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GROCCER</b>                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>               |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                       |                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>7232 PARK HTS. AVE. #21208</b>       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN WAGMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>DORA WAGMAN</b>                                                                     |                                                             |                                                                                                                                                             |                                     | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                    |  |                                                                |  |
| 16a. SOCIAL SECURITY NO<br><b>212-03-2093</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 17. INFORMANT<br><b>MRS. REVA WAGMAN</b>                                                                                           |                                                             |                                                                                                                                                             |                                     | 17a. ADDRESS<br><b>7232 PARK HTS. AVE., APT. 2-D #21208</b>                                                                     |  |                                                                |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Heart VD &amp; acute stenosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>many years</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>several</b> |  |                                                                                                                                    |                                                             |                                                                                                                                                             |                                     |                                                                                                                                 |  |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                             |                                                                                                                                                             |                                     |                                                                                                                                 |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                     |                                                                                                                                 |  |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                     |                                                                                                                                 |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> 19 <b>59</b> to <b>6-28</b> 19 <b>79</b> that (I) (we) last saw the deceased alive on <b>5-25</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                                                                            |  |                                                                                                                                    |                                                             |                                                                                                                                                             |                                     |                                                                                                                                 |  |                                                                |  |
| 22b. SIGNATURE<br><b>Stanley Steinbach</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                             | DEGREE<br><b>PHYSICIAN</b>                                                                                                                                  |                                     | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-28-79</b>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STANLEY STEINBACH, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                             | 22e. ADDRESS<br><b>11 SLADE AVE. BALTO., MD 21208</b>                                                                                                       |                                     |                                                                                                                                 |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>JUNE 29, 1979</b>                                                                                                  |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON (CHIZUK AMUNO)</b>                                                                                       |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b>                                                               |  |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                          |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                |  |                                                                |  |
| 26. ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                                             |                                                                                                                                                             |                                     |                                                                                                                                 |  |                                                                |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               |                                                                                                |                                                                     |                                                                                                                           |                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                           | 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MAURICE GEORGE WAGNER Sr.</b> |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br><b>6 20 79</b>             |                                                                                                | 2b HOUR<br><b>1:30a.</b>                                            |                                                                                                                           |                                                                               |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>WHITE</b>                                                                                                                                    |                                                                                          | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>12 12 17</b>                                                                                                          |                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>                                                    |                                                                     | 7a UNDER 1 YEAR MONTHS DAYS<br><b>YRS</b>                                                                                 |                                                                               |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                                                 |  | 7c CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                              |                                                                                          | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |                                                                     |                                                                                                                           |                                                                               |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                    |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |                                                                                          |                                                                                                                                                            |                                                               | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>              |                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Sign Co.</b>                                                                       |                                                                               |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                            |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                                            |                                                                                          | 13c CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |                                                               | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                     | 13e STREET ADDRESS<br><b>6810 Holabird Avenue</b>                                                                         |                                                                               |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Allen C. Wagner</b>                                                                                                                                                                                                                                                                                                                                    |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ellen R. Baier</b>                                                                                        |                                                                                          | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                             |                                                               | 16b SOCIAL SECURITY NO<br><b>1927-1941 212-16-9735</b>                                         |                                                                     | 17 INFORMANT ADDRESS<br><b>Emma C. Wagner Balto. MD 21222</b>                                                             |                                                                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute myocardial Infarction</b> |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               |                                                                                                |                                                                     |                                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>3 days</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                              |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               |                                                                                                |                                                                     |                                                                                                                           |                                                                               |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                           | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                          |                                                                                                                                                            |                                                               | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                     | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  |                                                                                                                                                           | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                            |                                                                                                                                                            |                                                               | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                     |                                                                                                                           |                                                                               |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                         |  |                                                                                                                                                           | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |                                                                                                                                                            |                                                               | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                  |                                                                     |                                                                                                                           |                                                                               |  |
| 22a I certify that (a) (this hospital) attended the deceased from <b>JUNE 17 19 79</b> , to <b>JUNE 20 19 79</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (he) deceased alive above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.                                                                                   |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               |                                                                                                |                                                                     |                                                                                                                           |                                                                               |  |
| 22b SIGNATURE<br><b>Steven B. Schwartz MD</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               | DEGREE<br><b>MD</b>                                                                            |                                                                     | 22c DATE SIGNED<br><b>6/20/79</b>                                                                                         |                                                                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven B. Schwartz, MD</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               | 22e ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>                                               |                                                                     |                                                                                                                           |                                                                               |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                           | 23b DATE<br><b>6/23/79</b>                                                               |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b> |                                                                                                | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |                                                                                                                           |                                                                               |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               | 25a DATE REC'D BY REGISTRAR<br><b>JUN 22 1979</b>                                              |                                                                     | 25b REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>                                                                        |                                                                               |  |
| 7922 Wise Avenue, Dundalk, MD 21222                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                           |                                                                                          |                                                                                                                                                            |                                                               |                                                                                                |                                                                     |                                                                                                                           |                                                                               |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                             |  |                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                             |  | 7 9 1 4 7 2 3                                                                                                                |  | REG. NO.                                                                                                                                                    |  |                                                                                             |  |                                                                                                                        |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN <del>LEE</del> LEO WALDO                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |  | 2a DATE OF DEATH MONTH DAY YEAR<br>6/6/79                                                                                                                   |  | 2b HOUR<br>10:45 A.M.                                                                       |  |                                                                                                                        |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br>White                                                                                                              |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>7/23/11                                                                                                                   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>67                                                   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey                                                                                                                                                                                                                                                                                                                                             |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                   |  |                                                                                                                        |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |                                                                                                                                                             |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stock Clerk                 |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Grocery Store                                                                      |  |
| 13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                              |  | 13b COUNTY<br>---                                                                                                            |  | 13c CITY OR TOWN<br>Baltimore                                                                                                                               |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>514 S. Gilmore St. 21223                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Waldo                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                              |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pearl (Unknown)                                                                                                |  |                                                                                             |  |                                                                                                                        |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                             |  | 16b SOCIAL SECURITY NO<br>172-10-1009                                                                                        |  | 17 INFORMANT ADDRESS<br>Shirley Waldo/514 S Gilmore St/21223                                                                                                |  |                                                                                             |  |                                                                                                                        |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the lung</u> |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                             |  |                                                                                                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                 |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                             |  |                                                                                                                        |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |  |                                                                                                                                                             |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                               |  |                                                                                             |  |                                                                                                                        |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                            |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                               |  |                                                                                             |  |                                                                                                                        |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/18</u> , 19 <u>79</u> , to <u>6/6</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/6/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.                                                    |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                             |  |                                                                                                                        |  |
| 22b SIGNATURE <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                             |  | 22c DATE SIGNED<br>6/6/79                                                                                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>ISLAM                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  | 22e ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229                                                                                                          |  |                                                                                             |  |                                                                                                                        |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                 |  | 23b DATE<br>06/09/79                                                                                                         |  | 23c NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery                                                                                                 |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co., Maryland                           |  |                                                                                                                        |  |
| 24 FUNERAL DIRECTOR NAME<br>Walters Funeral Home/Pratt & Stricker Streets                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  | 24b ADDRESS<br>21223                                                                                                                                        |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br>JUN 11 1979 <u>[Signature]</u>    |  |                                                                                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25 1 1 1 1 1



TO HOSPITAL ATTENDING PHYSICIAN: This form is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHAM-16 20M  
(VRA 15, 4) 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7 9                                                                                                                                           |  | 1 4 7 2 4                                                                                                                                                  |  | REG. NO.                                                                                                                                   |  |                                                                                                                           |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Juanita M. Walker</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 14, 1979</b>                                                                                                 |  | 2b HOUR<br><b>9:06pm</b>                                                                                                                   |  |                                                                                                                           |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br><b>White</b>                                                                                                                        |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 29, 1895</b>                                                                                               |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>                                                                                                |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                                                                           |  |                                                                                                                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Retired School Teacher</b>                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b COUNTY<br><b>Anne Arundel</b>                                                                                                             |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                             |  | 13e STREET ADDRESS<br><b>4038 Belle Grove Road 21225</b>                                                                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Reily Medford Garratt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wona</b>                                                                                   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                               |  |                                                                                                                                            |  |                                                                                                                           |  |
| 16b SOCIAL SECURITY NO.<br><b>245-14-4055</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 17 INFORMANT<br>ADDRESS<br><b>Mr. Paul H. Walker, Sr. Baltimore, Maryland 21225</b><br><b>4038 Belle Grove Road</b>                           |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>coronary artery disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>years</b> |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ventricular arrhythmia</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                           |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  |                                                                                                                                                            |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                        |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                     |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                           |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/9</b> 19 <b>79</b> to <b>6/14</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/14</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                    |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                           |  |
| 22b SIGNATURE<br><b>Stephen Wank</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |  | DEGREE                                                                                                                                                     |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>6/14/79</b>                                                                                         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen Wank</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 22e ADDRESS<br><b>601 N. Broadway 1 Balto. Md 21201</b>                                                                                                    |  |                                                                                                                                            |  |                                                                                                                           |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b DATE<br><b>June 18, 1979</b>                                                                                                              |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                                                                                           |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b>                                                           |  |                                                                                                                           |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home of Brooklyn 21225</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                         |  | 25b REGISTRAR'S SIGNATURE<br><b>Patricia Melroy</b>                                                                                        |  |                                                                                                                           |  |

MS. A. 1. P. 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RECORDED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14725

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         |                                                                                                         |                                           |      |           |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------|------|-----------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 1. DECEASED NAME (TYPE OR PRINT)                                                                        |                   | FIRST                                                                                                                                                    | MIDDLE           | LAST                                 | 2a. DATE KNOWN OF DEATH |                                                                                                         | <input checked="" type="checkbox"/> MONTH | DAY  | YEAR      | 2b. HOUR                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | WILLIAM C. WALKER                                                                                       |                   |                                                                                                                                                          |                  |                                      | 6 26 79                 |                                                                                                         |                                           |      |           | 5:55 P.M.                                    |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH                                                                                        | 6. AGE (IN YEARS) | IF UNDER 1 YR.                                                                                                                                           | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD             |                         | MONTH                                                                                                   | DAY                                       | YEAR | 5:55 P.M. |                                              |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | black   | 1 12 50                                                                                                 | 29 YRS.           |                                                                                                                                                          |                  | 6 26 79                              |                         |                                                                                                         |                                           |      |           |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                         |                                                                                                         |                                           |      |           |                                              |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | USA                                                                                                     |                   |                                                                                                                                                          |                  | Baltimore City                       |                         | MD.                                                                                                     |                                           |      |           |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                  | 12b. KIND OF BUSINESS OR INDUSTRY    |                         |                                                                                                         |                                           |      |           |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | Provident Hospital                                                                                      |                   |                                                                                                                                                          |                  |                                      |                         |                                                                                                         |                                           |      |           |                                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                         |                   | 13d. INSIDE CITY LIMITS?                                                                                                                                 |                  | 13e. STREET ADDRESS                  |                         |                                                                                                         |                                           |      |           |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                                                                             |                   | 13c. CITY OR TOWN                                                                                                                                        |                  | 5611 Haddon Avenue                   |                         |                                                                                                         |                                           |      |           |                                              |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                         |                   | Balto.                                                                                                                                                   |                  |                                      |                         |                                                                                                         |                                           |      |           |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 15. MOTHER'S MAIDEN NAME                                                                                |                   | 16. SOCIAL SECURITY NO.                                                                                                                                  |                  | 17. INFORMANT                        |                         | ADDRESS                                                                                                 |                                           |      |           |                                              |  |
| William T. Walker                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | Anna Cooper                                                                                             |                   | 216-54-6444                                                                                                                                              |                  | Dorothy A. Walker                    |                         | 5611 Haddon Ave.                                                                                        |                                           |      |           |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 16b. SOCIAL SECURITY NO.                                                                                |                   | 17. INFORMANT                                                                                                                                            |                  | ADDRESS                              |                         |                                                                                                         |                                           |      |           |                                              |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | 216-54-6444                                                                                             |                   | Dorothy A. Walker                                                                                                                                        |                  | 5611 Haddon Ave.                     |                         |                                                                                                         |                                           |      |           |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Gunshot wound to chest (unspecified)</b><br>IMMEDIATE CAUSE (a) <b>9654</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                               |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         |                                                                                                         |                                           |      |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         |                                                                                                         |                                           |      |           |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |                  |                                      |                         | 20. AUTOPSY?                                                                                            |                                           |      |           |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |                                           |      |           |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                         |                   | 21b. TIME OF INJURY 5:50 A.M. 8 26 79 P.M. 19                                                                                                            |                  |                                      |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) shot by unknown assailant |                                           |      |           |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street                                                                                       |                  |                                      |                         | 21f. LOCATION Liberty Hgts. & Eldorado Ave. Balto., Maryland                                            |                                           |      |           |                                              |  |
| 22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         |                                                                                                         |                                           |      |           |                                              |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                         |                   | TITLE (SPECIFY) Assistant                                                                                                                                |                  |                                      |                         | DATE SIGNED 6/27/79                                                                                     |                                           |      |           |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                         |                   | ADDRESS 111 Penn Street                                                                                                                                  |                  |                                      |                         |                                                                                                         |                                           |      |           |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                         |                   | 23b. DATE 6/30/79                                                                                                                                        |                  |                                      |                         | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.                                                     |                                           |      |           |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         | 23d. LOCATION Arbutus, Md.                                                                              |                                           |      |           |                                              |  |
| 24. FUNERAL DIRECTOR Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                         |                   | ADDRESS 1101 E. North Ave.                                                                                                                               |                  |                                      |                         | 25a. DATE REC'D. BY REGISTRAR JUN 29 1979                                                               |                                           |      |           |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                   |                                                                                                                                                          |                  |                                      |                         | 25b. REGISTRAR'S SIGNATURE <i>Dorothy A. Walker</i>                                                     |                                           |      |           |                                              |  |

22141 1/2





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14726

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                          |                                                                                                                                                            |                                                                                   |                                                                                                |                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>James Walter</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 6 79</b>                                                                                                       |                                                                                   | 2b. HOUR<br><b>2:30 P.M.</b>                                                                   |                                                                                                                           |
| 3 SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br><b>W</b>                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 13 12</b>                                                                                                      |                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                               |                                                                                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Md.</b>                              |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Smag</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b> |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                          | 13b COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c CITY OR TOWN<br><b>Baltimore</b>                                              | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>3718 Roland Ave</b>                                                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lester Walter</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                          | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ora Mason</b>                                                                                           |                                                                                   |                                                                                                |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                     |                                                                                                                          | 16b SOCIAL SECURITY NO.                                                                                                                                    |                                                                                   | 17 INFORMANT<br>ADDRESS<br><b>Mrs Stanley Bozman Princess Anne, Md</b>                         |                                                                                                                           |
| 18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c.<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Superior Vena Cava Obstruction</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>b) <b>metastatic squamous cell cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) |                                                                                                                          |                                                                                                                                                            |                                                                                   |                                                                                                |                                                                                                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>Peripheral vascular embolization</b>                                                                                                                                                                                                                             |                                                                                                                          |                                                                                                                                                            |                                                                                   |                                                                                                |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                          | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |                                                                                                                          | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                |                                                                                                                          | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5/8 1979</b> to <b>6/6 1979</b> , that (I) (we) last saw the deceased alive on <b>6/6 1979</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                                                                                      |                                                                                                                          |                                                                                                                                                            |                                                                                   |                                                                                                |                                                                                                                           |
| 22b SIGNATURE<br><b>J. H. A. B.</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                          | DEGREE<br><b>M.D.</b>                                                                                                                                      |                                                                                   | 22c DATE SIGNED<br><b>6/6/79</b>                                                               |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James H. Ackerman</b>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                          | 22e ADDRESS<br><b>Smag Hos, 27th</b>                                                                                                                       |                                                                                   |                                                                                                |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                               | 23b DATE<br><b>6/9/79</b>                                                                                                | 23c NAME OF CEMETERY OR CREMATORY<br><b>Asbury</b>                                                                                                         |                                                                                   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Princess Anne Somerset, Md</b>                 |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>James H. Ackerman</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                          | ADDRESS<br><b>Princess Anne Md</b>                                                                                                                         |                                                                                   | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                             |                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                          |                                                                                                                                                            |                                                                                   | 25b REGISTRAR'S SIGNATURE<br><b>Harry McCreedy</b>                                             |                                                                                                                           |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                              |  | 9 1 4 7 2 7     |     |            |          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|------------------------------|--|-----------------|-----|------------|----------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | REG. NO.                                                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                          |  | FIRST                                                                                                                                           |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2a. DATE OF DEATH            |  | MONTH           | DAY | YEAR       | 2b. HOUR |
| CHARLES E. WARD                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  | 6 15 1979                    |  |                 |     |            | 9 P.M.   |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                                                         |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR              |  | IF UNDER 24 HRS |     |            |          |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | White                                                                                                                                           |  | Oct 11, 1907                                                                                                                                             |  | 71 yrs                                                              |  | MONTHS                       |  | DAYS            |     | HOURS MIN. |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                              |  |                 |     |            |          |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                                                                                          |  |                                                                                                                                                          |  | Baltimore city                                                      |  |                              |  |                 |     | MD.        |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                              |  |                 |     |            |          |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | North Charles General Hosp.                                                                                                                     |  | Retired                                                                                                                                                  |  | --                                                                  |  |                              |  |                 |     |            |          |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY                                                                                                                                     |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS          |  |                 |     |            |          |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | --                                                                                                                                              |  | Baltimore                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 903 West 33rd Street (21211) |  |                 |     |            |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | FIRST MIDDLE LAST                                                                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| William C. Ward                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | unknown                                                                                                                                         |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                                                                        |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                              |  |                 |     |            |          |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 213-03-3973                                                                                                                                     |  | Mrs. Dorothy Ward-903 W. 33rd St. (21211)                                                                                                                |  |                                                                     |  |                              |  |                 |     |            |          |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u><br><u>4148</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A.S.C.V.D. and 3 M.I. in the past</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Right Cerebral Thrombosis B. lateral pneumonia - Staph. Viridans</u>                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                              |  |                 |     |            |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                              |  |                 |     |            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                              |  |                 |     |            |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                              |  |                 |     |            |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/10/75</u> to <u>6/15/75</u> , that (I) (we) last saw the deceased alive on <u>6/15/75</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                                                          |  | 22c. DATE SIGNED                                                                                                                                         |  |                                                                     |  |                              |  |                 |     |            |          |
| <u>K. Dharmasena</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 6/15/75                                                                                                                                                  |  |                                                                     |  |                              |  |                 |     |            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                                                                    |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| K. DHARMASENA                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2724 N. Charles St. Baltimore Md 21218                                                                                                          |  |                                                                                                                                                          |  |                                                                     |  |                              |  |                 |     |            |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                              |  |                 |     |            |          |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6/19/79                                                                                                                                         |  | Parkwood Cemetery                                                                                                                                        |  | Baltimore, Maryland                                                 |  |                              |  |                 |     |            |          |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                              |  |                 |     |            |          |
| A. Alan Seitz Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 3818 Roland Ave.                                                                                                                                |  | JUN 19 1979                                                                                                                                              |  | <u>Dorothy M. Kennedy</u>                                           |  |                              |  |                 |     |            |          |

V. S. V. P. I. 9. V.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 2 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                         |                                                                                                                              |                                                                                                                                                             |                                                                          |                                                         |
|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST (LEILA) MIDDLE E LAST WARD |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 3 79                                                                                                               |                                                                          | 2b. HOUR<br>3:25 P.M.                                   |
| 3. SEX<br>F                                                             | 4. RACE<br>BLACK                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 18 01                                                                                                               |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.                        | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD. |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSP. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET. | 12b. KIND OF BUSINESS OR INDUSTRY                       |

|                                                                                         |             |                                                                                                 |                                          |
|-----------------------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------|------------------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2254 MADISON AVE. |
| 13a. STATE<br>MD.                                                                       | 13b. COUNTY | 13c. CITY OR TOWN<br>BALTO                                                                      |                                          |

|                                                      |                                                                     |
|------------------------------------------------------|---------------------------------------------------------------------|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John DAVES | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HALLIE C. CHAMBERS |
|------------------------------------------------------|---------------------------------------------------------------------|

|                                                                            |                                        |                                                                   |
|----------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO | 16b. SOCIAL SECURITY NO.<br>052-14-816 | 17. INFORMANT<br>ADDRESS<br>MRS. BERTHA WILSON 1651 CLIFFVIEW AVE |
|----------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory Failure<br>4151<br>DUE TO, OR AS A CONSEQUENCE OF (b) Intractable Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) Pulmonary embolism with pulmonary infarction<br>DUE TO, OR AS A CONSEQUENCE OF AUTOPSY FINDING |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                      |  |                                              |

|                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                                            |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 6:22 to 6:2 1979, that (I) (we) last saw the deceased alive on 6:3 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                            |
| 22b. SIGNATURE<br>Belmont M.D.                                                                                                                                                                                                                                                                       | DEGREE                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>6/5/79                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                | 22e. ADDRESS<br>Provident Hospital                                     |                                                                                                                                            |                                                                                                                            |

|                                                        |                     |                                                  |                                                          |
|--------------------------------------------------------|---------------------|--------------------------------------------------|----------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>6-8-79 | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Samuel T. Redd         |                     | ADDRESS<br>5209 YORK Rd. BALTO. MD.              | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979             |
|                                                        |                     | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |                                                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE OFFICE OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
IVR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 14729

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 2a. DATE KNOWN OF DEATH                                     |                                                               | MONTH DAY YEAR                                                                |                                   | 2b. HOUR                                                            |                                              |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 3. DATE OF BIRTH                                            |                                                               | 4. AGE (IN YEARS)                                                             |                                   | 7c. DATE PRONOUNCED DEAD                                            |                                              |
| LEONARD WARE                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 3/24/15                                                     |                                                               | 67                                                                            |                                   | 6 4 19 79                                                           |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE                                                                                                 | 5. DATE OF BIRTH                                            |                                                               | 6. AGE (IN YEARS)                                                             |                                   | 7c. DATE PRONOUNCED DEAD                                            |                                              |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                            | negro                                                                                                   | 3/24/15                                                     |                                                               | 67                                                                            |                                   | 6 4 19 79                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                            | 8. MARRIED                                                  |                                                               | NEVER MARRIED                                                                 |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                              |
| Va.                                                                                                                                                                                                                                                                                                                                                                                                                                             | U.S.A.                                                                                                  | WIDOWED                                                     |                                                               | DIVORCED                                                                      |                                   | Baltimore City                                                      |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                     |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1510 Fremont Ave.                                                                                       |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN                                           |                                                               | 13d. INSIDE CITY LIMITS?                                                      |                                   | 13e. STREET ADDRESS                                                 |                                              |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         | Baltimore                                                   |                                                               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                   |                                                                     |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | 15. MOTHER'S MAIDEN NAME                                    |                                                               |                                                                               |                                   |                                                                     |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | FIRST MIDDLE LAST                                           |                                                               |                                                                               |                                   |                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 16b. SOCIAL SECURITY NO.                                    |                                                               | 17. INFORMANT ADDRESS                                                         |                                   |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: <u>Arteriosclerotic cardiovascular disease</u>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| IMMEDIATE CAUSE (a) <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                               |                                                                               |                                   | 20. AUTOPSY?                                                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                             |                                                               |                                                                               |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                             |                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | P.M. 19                                                     |                                                               |                                                                               |                                   |                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                   |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                                                                         |                                                             |                                                               |                                                                               |                                   |                                                                     |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | TITLE (SPECIFY)                                             |                                                               | DATE SIGNED                                                                   |                                   |                                                                     |                                              |
| Virginia L. Dolan M.D.                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | Assistant                                                   |                                                               | 6-5-79                                                                        |                                   |                                                                     |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | ADDRESS                                                     |                                                               |                                                                               |                                   |                                                                     |                                              |
| Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 111 Penn St.                                                |                                                               |                                                                               |                                   |                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 23b. DATE                                                   |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 6-12-79                                                     |                                                               | Mt Calvary                                                                    |                                   | Baltimore Md                                                        |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | ADDRESS                                                     |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                 |                                   | 25b. REGISTRAR'S SIGNATURE                                          |                                              |
| Brown P. Canale                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 1712-14 W. Mc Ave                                           |                                                               | JUN 25 1979                                                                   |                                   | Anthony A. Brady                                                    |                                              |

PSA 1 8V





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14730

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                  |  |                                                                                                                                    |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------|--|-------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 1. DECEASED NAME (TYPE OR PRINT) |  | FIRST<br>John                                                                                                                      |  | MIDDLE<br>F                                                                                     |  | LAST<br>Warner                                                                                                                                              |  | 2a. DATE KNOWN OF DEATH ESTI- MATED                                        |  | MONTH<br>6                                                 |  | DAY<br>14                                       |  | YEAR<br>1979                                                                        |  | 2b. HOUR<br>9:35 a. m.                       |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>white                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 17 98                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                                      |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS.<br>HOURS MIN.                                             |  | 7c. DATE PRONOUNCED DEAD                                   |  | MONTH<br>6                                      |  | DAY<br>14                                                                           |  | YEAR<br>1979                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                               |  |                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |                                                 |  |                                                                                     |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |                                                                                                 |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Draftsman |  |                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Stationary |  |                                                                                     |  |                                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                             |  |                                  |  |                                                                                                                                    |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br>--                |  | 13c. CITY OR TOWN<br>Balto.                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3116 Clifftmont Ave.                                                                                                                 |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                         |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                              |  |                                  |  | 16b. SOCIAL SECURITY NO.<br>WWI 163-07-7746                                                                                        |  |                                                                                                 |  | 17. INFORMANT ADDRESS                                                                                                                                       |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292. IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                    |  |                                  |  |                                                                                                                                    |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                                         |  |                                  |  |                                                                                                                                    |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                        |  |                                                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                  |  |                                                                                                                                    |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| ACTUAL SIGNATURE <u>H. Guard</u>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                  |  | TITLE (SPECIFY)<br>Assistant                                                                                                       |  |                                                                                                 |  | M.D. MEDICAL EXAMINER                                                                                                                                       |  |                                                                            |  | DATE SIGNED<br>6/14/79                                     |  |                                                 |  |                                                                                     |  |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                               |  |                                  |  | ADDRESS<br>111 Penn Street, Baltimore, MD 21201                                                                                    |  |                                                                                                 |  |                                                                                                                                                             |  |                                                                            |  |                                                            |  |                                                 |  |                                                                                     |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                  |  | 23b. DATE<br>6/14/79                                                                                                               |  |                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                    |  |                                                 |  |                                                                                     |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                  |  | ADDRESS<br>Balto., Md.                                                                                                             |  |                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                                                                                |  |                                                                            |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patrick McCready</u>      |  |                                                 |  |                                                                                     |  |                                              |  |

001-1-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                             |                                                                                          |                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alex Joseph Washegesic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 26, 1979</b> |                                                                                          | 2b. HOUR<br><b>9:50</b> AM |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>American Indian</b>                                                                                                             |                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 5, 1917</b>                                |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                        |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>US Public Health Hospital</b> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD                        |                            |  |
| 13a. STATE<br><b>Michigan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Schoolcraft</b>                                                                                                             |                                                             | 13c. CITY OR TOWN<br><b>Manistique</b>                                                   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Washegesic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Peters</b>                                                                          |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>American Sea.</b> |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>363-24-1143</b>                                                                                                |                                                             | 17. INFORMANT<br>ADDRESS<br><b>Records-US Public Health Hospital</b>                     |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>185-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Widespread carcinoma metastasis</b><br>(c) <b>Biliary tract obstruction</b><br>(d) <b>Prostatic carcinoma with metastasis</b><br>(e) <b>PANCREATIC CARCINOMA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>Months</b><br><b>3 YEARS</b><br><b>48 hr + 2 hour</b> |  |                                                                                                                                               |                                                             |                                                                                          |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITION (S) OF THE BODY OR MIND AT TIME OF DEATH (GIVEN IN PART 1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                             |                                                                                          |                            |  |
| 19a. DATE OF OPERATION<br><b>6/14/79</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Biliary Tract Obstruction</b>                                                          |                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 21</b> , 19 <b>79</b> , to <b>June 26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                             |                                                                                          |                            |  |
| 27b. SIGNATURE<br><b>Edward J. Ausman, DO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | DEGREE<br><b>DO</b>                                                                                                                           |                                                             | 27c. DATE SIGNED                                                                         |                            |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward J. Ausman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 27e. ADDRESS<br><b>Baltimore USPHS - Hospital.</b>                                                                                            |                                                             |                                                                                          |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>6/30/1979</b>                                                                                                                 |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Cemetery</b>                          |                            |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>South Haven</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | COUNTY<br><b>Michigan</b>                                                                                                                     |                                                             | STATE                                                                                    |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. Barnes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br><b>Fleming Funeral Service - Benson, Md. 21018</b>                                                                                 |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                      |                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McCready</b>                                   |                            |  |

BP

1 4 3 3 1



Joseph Washington  
March 26, 1917  
USA  
US Public Health Hospital  
Mexico City  
March 26, 1917

March 26, 1917  
US Public Health Hospital  
Mexico City

March 26, 1917  
US Public Health Hospital  
Mexico City

March 26, 1917  
US Public Health Hospital  
Mexico City



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 7 9 1 4 7 3 2<br>REG. NO.                                                                                                                        |  |                                                                                                                         |  |                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                 |  |                                                                                                                         |  | 2b. HOUR                                                                          |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>QUAM BR WASHINGTON                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  | 6/7/79                                                                                                                                           |  |                                                                                                                         |  | 11:59 AM                                                                          |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>BLACK                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 7 79                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) NB YRS                                                                                  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                              |  |                                                                                   |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |  |                                                                                                                                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>—                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                                            |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |  | 13b. COUNTY                                                                                                                                      |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JONATHAN A 17 DRIEHL                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>GUAN WASHINGTON                                                                                    |  | 13e. STREET ADDRESS<br>359 WILSON ST                                                                                    |  |                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.                                                                                                          |  | 17. INFORMANT ADDRESS<br>NATHANIEL WASHINGTON FOREST HILL RD                                                                                     |  |                                                                                                                         |  |                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumothorax - Severe Hyaline Membrane Disease</u><br>769-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe hyaline membrane disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pre maturity</u> |  |                                                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                         |  |                                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                   |  |                                                                                                                         |  |                                                                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                   |  |                                                                                                                         |  |                                                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/7/79 at 19:45</u> to <u>6/7/79 at 19:11:59 AM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                  |  |                                                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                         |  |                                                                                   |  |
| 22b. SIGNATURE<br>Saroj Menta                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                                                                         |  | 22c. DATE SIGNED<br>6/7/79                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAROJ MENTA                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL                                                                                                          |  |                                                                                                                         |  |                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br>6-10-79                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Berkley                                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Darlington Harford Md.                                                       |  |                                                                                   |  |
| 24. FUNERAL DIRECTOR NAME<br>George W. Tittle                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | ADDRESS<br>Bel Air, MD.                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 14 1979                                                                            |  | 25b. REGISTRAR'S SIGNATURE<br>Pistony McCreedy                                    |  |

5 3 7 4 1 2 2



Items #18a-22a Film G533 7/12/79 rg  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

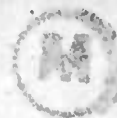
REG. NO. 14733

|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  |                                           |  |                                               |  |                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|------------------------------------------------------|--|-------------------------------------------|--|-----------------------------------------------|--|----------------------------------------------------------|--|
| 1. STATE REGISTRAR                                                                                                                                                                                                   |  | 2a. DATE KNOWN OF DEATH                      |  | 2b. DATE ESTI. MATED                                 |  | 2c. DATE PRONOUNCED DEAD                  |  | 2d. DATE OF DEATH                             |  | 2e. HOUR                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                     |  | 3. SEX                                       |  | 4. RACE                                              |  | 5. DATE OF BIRTH                          |  | 6. AGE (IN YEARS)                             |  | 7. IF UNDER 1 YR.                                        |  |
| JAMES WASHINGTON                                                                                                                                                                                                     |  | male                                         |  | black                                                |  | JULY 24, '76                              |  | 2 YRS                                         |  | IF UNDER 24 HRS                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                 |  | 8. MARRIED                                           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH      |  | 10. CITY OR TOWN OF DEATH                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |
| BALTO., MD.                                                                                                                                                                                                          |  | U. S. A.                                     |  | NEVER MARRIED XX                                     |  | Baltimore City                            |  | Baltimore                                     |  | 523 N. Carey Street                                      |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                      |  | 13a. STATE                                   |  | 13b. COUNTY                                          |  | 13c. INSIDE CITY LIMITS?                  |  | 13d. STREET ADDRESS                           |  | 14. FATHER'S NAME                                        |  |
| N/A                                                                                                                                                                                                                  |  | MARYLAND                                     |  | BALTIMORE                                            |  | YES X NO                                  |  | 523 N. CAREY STREET                           |  | JAMES L. WASHINGTON                                      |  |
| 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |  | 16b. SOCIAL SECURITY NO.                             |  | 17. INFORMANT                             |  | 18. CAUSE OF DEATH                            |  | 19. DATE OF OPERATION                                    |  |
| RHONDA E. WASHINGTON                                                                                                                                                                                                 |  | NO.                                          |  | -----                                                |  | MRS. HALLIE MOONEY                        |  | 3439 Cerebral Palsy due to Perinatal asphyxia |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |
| ADDRESS                                                                                                                                                                                                              |  | (YES, NO, OR UNKNOWN)                        |  | (IF YES, GIVE WAR OR DATES)                          |  | 1014 W. LAFAYETTE AV                      |  | IMMEDIATE CAUSE (a)                           |  | 20. AUTOPSY?                                             |  |
|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  |                                           |  | DUE TO, OR AS A CONSEQUENCE OF                |  | YES X NO                                                 |  |
|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  |                                           |  | (b)                                           |  |                                                          |  |
|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  |                                           |  | DUE TO, OR AS A CONSEQUENCE OF                |  |                                                          |  |
|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  |                                           |  | (c)                                           |  |                                                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                       |  |                                              |  |                                                      |  |                                           |  |                                               |  |                                                          |  |
| 21a. EXTERNAL CAUSE WAS                                                                                                                                                                                              |  | 21b. TIME OF INJURY                          |  | 21c. HOW INJURY OCCURRED                             |  | 21d. INJURY OCCURRED                      |  | 21e. PLACE OF INJURY                          |  | 21f. LOCATION                                            |  |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                            |  | HOUR A.M. MONTH DAY YEAR                     |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | WHILE NOT WHILE AT WORK                   |  | STREET, FACTORY, FARM, ETC.)                  |  | STREET CITY OR TOWN COUNTY STATE                         |  |
|                                                                                                                                                                                                                      |  | P.M. 19                                      |  |                                                      |  |                                           |  |                                               |  |                                                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner. |  |                                              |  |                                                      |  |                                           |  |                                               |  |                                                          |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                     |  | TITLE (SPECIFY)                              |  | DATE SIGNED                                          |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE                                     |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |
| Virginia L. Dolan                                                                                                                                                                                                    |  | Assistant                                    |  | 6/7/79                                               |  | BURIAL                                    |  | 6/12/79                                       |  | WESTVIEW CEMETERY                                        |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                      |  | ADDRESS                                      |  | 23d. LOCATION                                        |  | 24. FUNERAL DIRECTOR                      |  | 25a. DATE REC'D. BY REGISTRAR                 |  | 25b. REGISTRAR'S SIGNATURE                               |  |
| Virginia L. Dolan, M.D.                                                                                                                                                                                              |  | 111 Penn Street, Balto. MD 21201             |  | BALTIMORE, MARYLAND                                  |  | LEROY O. DYETT & SON                      |  | JUN 13 1979                                   |  | F. J. Kelly                                              |  |
|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  | NAME ADDRESS                              |  |                                               |  |                                                          |  |
|                                                                                                                                                                                                                      |  |                                              |  |                                                      |  | 4600 LIBERTY HGTS. AVE.                   |  |                                               |  |                                                          |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

02741 81







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14734

|                                                                                                                                    |  |                                         |  |                                                                                                                                                                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. STATE REGISTRAR                                                                                                                 |  | 2a. DATE KNOWN OF DEATH                 |  | 2b. HOUR                                                                                                                                                                                                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                   |  | 3. SEX                                  |  | 4. RACE                                                                                                                                                                                                                   |  |
| Nathaniel Washington                                                                                                               |  | male                                    |  | black                                                                                                                                                                                                                     |  |
| 5. DATE OF BIRTH                                                                                                                   |  | 6. AGE (IN YEARS)                       |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                  |  |
| 10 - 6 - 1924                                                                                                                      |  | 54 YRS.                                 |  | S.C.                                                                                                                                                                                                                      |  |
| 8. MARRIED                                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH    |  | 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                 |  |
| WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | Baltimore City                          |  | Baltimore                                                                                                                                                                                                                 |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                           |  | 12. USUAL OCCUPATION (TYPE OF WORK)     |  | 13. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                          |  |
| 2819 E. Biddle Street                                                                                                              |  | Construction                            |  | Const.                                                                                                                                                                                                                    |  |
| 14. FATHER'S NAME                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                   |  |
| Mitchell Washington                                                                                                                |  | Isabella Rouse                          |  | 239-56-3820                                                                                                                                                                                                               |  |
| 17. INFORMANT                                                                                                                      |  | 18. CAUSE OF DEATH                      |  | 19. DATE OF OPERATION                                                                                                                                                                                                     |  |
| Mrs. Isabella Washington                                                                                                           |  | Arteriosclerotic cardiovascular disease |  | Head only                                                                                                                                                                                                                 |  |
| 20. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  | 21. TIME OF INJURY                      |  | 22. I certify that I took charge of the remains described above, held on                                                                                                                                                  |  |
| chronic alcoholism                                                                                                                 |  | P.M. 19                                 |  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| 23. BURIAL, CREMATION, REMOVAL                                                                                                     |  | 24. FUNERAL DIRECTOR                    |  | 25. DATE REC'D. BY REGISTRAR                                                                                                                                                                                              |  |
| Burial                                                                                                                             |  | Joseph L. Russ                          |  | JUN 25 1979                                                                                                                                                                                                               |  |

MEDICAL CERTIFICATION

100-100-100

3

2

100-100-100

100-100-100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 7 3 5

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                      |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                          |  | 2b. HOUR                                                                                                                |  |
| I. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                            |  | FIRST MIDDLE LAST                                                                                      |  | 6 13 79                                                                                                                                                 |  | M                                                                                                                       |  |
| William L. Washington, Sr.                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                       |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH                                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                          |  |
| Male                                                                                                                                                                                                                                                                                                                        |  | Black                                                                                                  |  | MONTH DAY YEAR<br>2 15 15                                                                                                                               |  | 64 YRS                                                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                     |  |
| Va.                                                                                                                                                                                                                                                                                                                         |  | USA                                                                                                    |  |                                                                                                                                                         |  | Baltimore City MD.                                                                                                      |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| Balto.                                                                                                                                                                                                                                                                                                                      |  | 3518 Spaulding Ave.                                                                                    |  |                                                                                                                                                         |  |                                                                                                                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                     |  | 13a. STATE                                                                                             |  | 13b. COUNTY                                                                                                                                             |  | 13c. CITY OR TOWN                                                                                                       |  |
| Md.                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | Balto.                                                                                                                                                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME                                                                                |  | 13e. STREET ADDRESS                                                                                                                                     |  |                                                                                                                         |  |
| George Washington                                                                                                                                                                                                                                                                                                           |  | Martha Anderson                                                                                        |  | 3518 Spaulding Ave.                                                                                                                                     |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17 INFORMANT                                                                                                                                            |  | ADDRESS                                                                                                                 |  |
| No                                                                                                                                                                                                                                                                                                                          |  | 219-01-1438                                                                                            |  | Beverly Washington                                                                                                                                      |  | 3518 Spaulding Ave                                                                                                      |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)                                                                                                                                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                           |  |                                                                                                                                                         |  |                                                                                                                         |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive brain metastasis</u>                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 1539                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                              |  | (b) <u>Adenocarcinoma of colon</u>                                                                     |  |                                                                                                                                                         |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                             |  | (c)                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 22b. SIGNATURE <u>Joachim Z. Fuks</u>                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                         |  |                                                                                                                         |  |
| Joachim Z. Fuks                                                                                                                                                                                                                                                                                                             |  | Baltimore Lower Remond Center                                                                          |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |
| Burial                                                                                                                                                                                                                                                                                                                      |  | 6/16/79                                                                                                |  | Arubutn Mem. Pk.                                                                                                                                        |  | Arbutus, Md.                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                   |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  | 25b. REGISTERED                                                                                                         |  |
| Wm C March F/H                                                                                                                                                                                                                                                                                                              |  | 1101 E. North Ave.                                                                                     |  | JUN 18 1979                                                                                                                                             |  | <u>Fitzpatrick</u>                                                                                                      |  |

MEDICAL CERTIFICATION

6811 87



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 7 3 6

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                |                                                                                                                                                          |                             |                                                                                     |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HANNAH ANNE TYSON                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 18 79 |                                                                                                                                                          |                             | 2b. HOUR<br>10:18 <sup>00</sup> AM                                                  |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>WHITE                                                                                                                     |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 26 13                                                                                                            |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                          |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                               |                                        |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US                                                                                                   |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.                              |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                |                                                                                                                                                          |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ADMISSIONS DIR. |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>KESNICK HOME                                                                                          |                                        |                                                                                                                            |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      | 13b. COUNTY<br>BALTO.                          |                                                                                                                                                          | 13c. CITY OR TOWN<br>BALTO. |                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br>4206 ROLAND AVE |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM J. H. WATTERS                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HANNAH T. LEE                                                                                           |                             |                                                                                     |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |                                                | 16b. SOCIAL SECURITY NO.<br>218-01-3201                                                                                                                  |                             | 17. INFORMANT<br>G.W. CONSTABLE                                                     |                                                                                                 |                                                                                                                                            |                                        | ADDRESS<br>BALTO, MD                                                                                                       |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF <u>COPD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u> |  |                                                                                                                                      |                                                |                                                                                                                                                          |                             |                                                                                     |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                |                                                                                                                                                          |                             |                                                                                     |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                             |                                                                                     |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <u>6/18</u> 19 <u>79</u> to <u>6/18</u> 19 <u>79</u> , that (I) (we) lost <u>6/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                                                                                                                 |  |                                                                                                                                      |                                                |                                                                                                                                                          |                             |                                                                                     |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                | DEGREE<br>MD                                                                                                                                             |                             |                                                                                     |                                                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                        | 22c. DATE SIGNED<br>6/18/79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRED DOUGAN                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                | 22e. ADDRESS<br>15 E Biddle St Baltimore Md 21202                                                                                                        |                             |                                                                                     |                                                                                                 |                                                                                                                                            |                                        |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |                                                | 23b. DATE<br>6-21-79                                                                                                                                     |                             | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral                                 |                                                                                                 | 23d. LOCATION<br>Balto.                                                                                                                    |                                        | COUNTY STATE<br>Md.                                                                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H.W. Jenkins & Sons Co. Balto., Md.                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |                                                | ADDRESS<br>4905 York Rd.                                                                                                                                 |                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                           |                                        |                                                                                                                            |  |

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

001111

04-25-03 10:07 AM

122217

... ..

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 7 3 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                 |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                    |                                                      |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT AUGUST WEAVER</b>                 |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>6</b> YEAR <b>79</b>                                 |                                                    | 2b. HOUR<br><b>200p.m.</b>                           |
| 3. SEX<br><b>MALE</b>                                                           | 4. RACE<br><b>White</b>                                                                                                                      | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>10</b> YEAR <b>1932</b>                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>                                                    |                                                    | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>     |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>MD</b>                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                                    |                                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen Hosp</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Sales (ret)</b>    |                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SelfEmp.</b> |
| 13a. STATE<br><b>MD</b>                                                         | 13b. COUNTY<br><b>AA</b>                                                                                                                     | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                                                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>105 Leymar Bk.</b>       |                                                      |
| 14. FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b>M.</b> LAST <b>Weaver</b>      |                                                                                                                                              | 15. MOTHER'S M maiden NAME<br>FIRST <b>ROIA</b> MIDDLE <b>SHORES</b>                                                                                        |                                                                                                 |                                                    |                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>n/a</b> |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>218269740</b>                                                                                                                |                                                                                                 | 17. INFORMANT (wife) ADDRESS<br><b>Same as #13</b> |                                                      |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

**Pulmonary EMBOLISM**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) **CHRONIC CAF**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASCVD with previous myocardial infarction**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

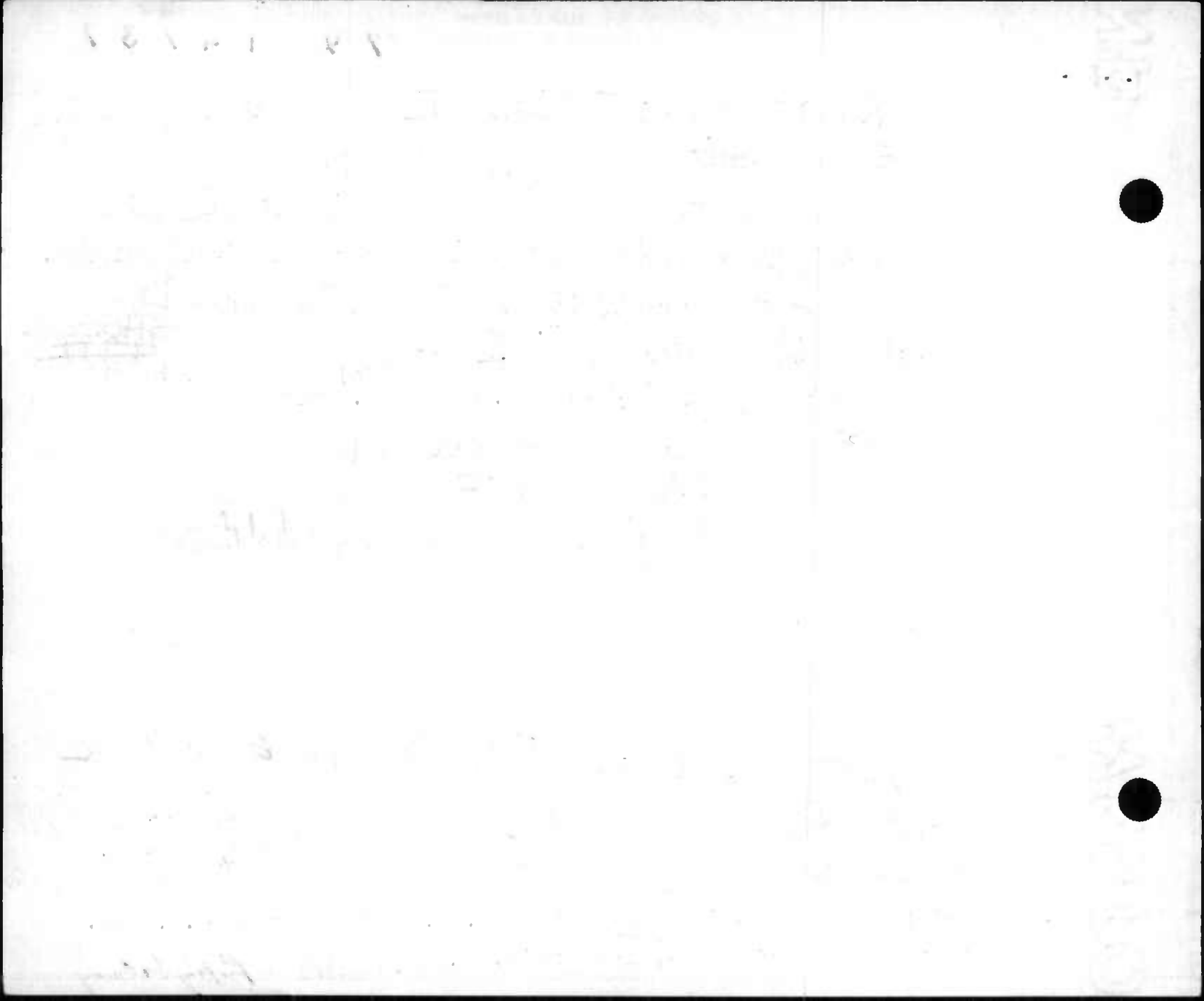
|                                                                                                                                                                                               |                                                                        |                                                                                                                                                       |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                                                                        |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                     |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>above, (I) (we) (did not) view the body after death. <b>6-6-79</b> <b>5-19-79</b> to <b>6-6-79</b> , that (I) (we) last |                                                                        |                                                                                                                                                       |                                                                                                                               |
| 22b. SIGNATURE<br><b>Andrew Cowley</b>                                                                                                                                                        | DEGREE <b>MD</b>                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>6-6-79</b>                                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andrew Cowley</b>                                                                                                                                 |                                                                        |                                                                                                                                                       |                                                                                                                               |
| 22e. ADDRESS<br><b>South Baltimore Gen Hosp.</b>                                                                                                                                              |                                                                        |                                                                                                                                                       |                                                                                                                               |

|                                                                                             |                                   |                                                                  |                                                                           |
|---------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                               | 23b. DATE<br><b>June 11, 1979</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>Singleton</b> ADDRESS <b>Funeral Home, Glen Burnie, Md.</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1979</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. Kelly</b>                          |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                 |                                                                           |                                                                         |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lena O Weber</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6 18 79</b>                     |                                                                                                                                                             | 2b. HOUR<br><b>6:35</b> M                                                       |                                                                           |                                                                         |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 18 1883</b>                                                                                                         |                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.                         |                                                                         |                                                                                                                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Baltimore, Md</b>                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                  |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>         |                                                                         |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wesley Home</b> |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                       |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b>                                                                                                                                                                                                                                                        |  |                                                                                                                              |                                                                        | 13b. COUNTY <b>-</b>                                                                                                                                        |                                                                                 | 13c. CITY OR TOWN <b>Baltimore</b>                                        |                                                                         |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Edward Weber</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Louise Ohlgart</b>                                                                                         |                                                                                 |                                                                           |                                                                         |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-6195</b>                                                                               |                                                                        | 17. INFORMANT<br><b>A Chart</b>                                                                                                                             |                                                                                 |                                                                           |                                                                         |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4379</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                 |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Years</b>            |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                         |  |                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                 |                                                                           |                                                                         |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  |                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                                                           |                                                                         |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                |  |                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                                                           |                                                                         |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                 |                                                                           |                                                                         |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Daniel J Winn MD</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              | DEGREE                                                                 |                                                                                                                                                             |                                                                                 | 22c. DATE SIGNED<br><b>6/18/79</b>                                        |                                                                         |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel J Winn</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              | 22e. ADDRESS<br><b>2211 W. ROGERS AVE</b>                              |                                                                                                                                                             |                                                                                 |                                                                           |                                                                         |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              | 23b. DATE<br><b>20 June 79</b>                                         |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                 |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Md</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                       |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |  |

8 2 7 1 6 7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 7 3 9

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Richard Lee Weekly</b>                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 2, 1979</b>                           |                                                                                                            | 2b. HOUR<br><b>7:14 PM</b>                      |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>White</b>                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 13, 1932</b>                                                                                                  |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.<br># UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN. |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                          |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>The Johns Hopkins Hospital</b> |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b>                         |                                                 |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Aluminum Co.</b>                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>W. Va. 13b. County 13c. Paden</b>                                                                                                                                                                                |                                                                                              |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                            |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry B. Weekly</b>                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Guthrie</b>                |                                                                                                            |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                              |                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>234 46 8769</b>                                                                                                              |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Glen Weekly Huntington, W. Va.</b>                                          |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver Failure</b><br><b>1561</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bile Duct Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Failure, Pneumonia</b>                                                   |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                 |
| 19a. DATE OF OPERATION<br><b>5/1/79</b>                                                                                                                                                                                                                                                                                                                         |                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bile Duct Obstruction</b>                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |                                                 |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/26 19 79</b>                                                                                        |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                             |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                    |                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                          |                                                 |
| 22. I certify that (1) (this hospital) attended the deceased from <b>4/26</b> , 19 <b>79</b> , to <b>6/2</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                 |
| 22b. SIGNATURE<br><b>R G Postier MD</b>                                                                                                                                                                                                                                                                                                                         |                                                                                              | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED<br><b>6/2/79</b>                                                                          |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R G Postier</b>                                                                                                                                                                                                                                                                                                     |                                                                                              | 22e. ADDRESS<br><b>Johns Hopkins Hosp.</b>                                                                                                                  |                                                                                      |                                                                                                            |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                |                                                                                              | 23b. DATE<br><b>6-5-79</b>                                                                                                                                  |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                                                    |                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                             |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1979</b>                                                         |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                                                             |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                           |                                                 |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

95741-5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14740

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                                                                            |                                                              |                                                                                     |                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARtha W WEINAL                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>6 23 79                |                                                                                     | 2b HOUR<br>3 P.M.                                                                                                         |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                     | 4 RACE<br>Caucasian                                                                                                                  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>May 3 1898                                                                                                            |                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81                                                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                 |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>North Carolina                                                                                                                                                                                                                                                                                                                                                                  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                              | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT A HEALTH FACILITY, GIVE STREET ADDRESS)<br>North Charles Gen Hosp |                                                                                                                                                            |                                                              | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>at home          |                                                                                                                           |
| 13a STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                                                                            | 13b COUNTY<br>Anne Arundel                                   | 13c CITY OR TOWN<br>Glenburnie                                                      | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>David J. Nell                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gertrude Chapman                                                                                           |                                                              |                                                                                     |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | 16b SOCIAL SECURITY NO.<br>21554-1281                                                                                                                      |                                                              | 17 INFORMANT<br>Family Records                                                      |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) STAPHYLOCOCCAL PNEUMONIA<br>4824<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>several days |                                                                                                                                      |                                                                                                                                                            |                                                              |                                                                                     |                                                                                                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>RENAL FAILURE; ASCVD                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                            |                                                              |                                                                                     |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                              | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |                                                                                                                           |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from 6/16, 1979, to 6/23, 1979, that (I) (we) last saw the deceased alive on 6/23, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                  |                                                                                                                                      |                                                                                                                                                            |                                                              |                                                                                     |                                                                                                                           |
| 22b. SIGNATURE<br>Veneranda G. Barnes M.D.                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                            | DEGREE<br>M.D.                                               |                                                                                     | 22c. DATE SIGNED<br>6/23/79                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VENERANDA G. BARNES M.D.                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                            | 22e. ADDRESS<br>NORTH CHARLES GEN. HOSP.                     |                                                                                     |                                                                                                                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Specify)                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 23b. DATE<br>6-26-79                                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                                                |
| 24 FUNERAL DIRECTOR<br>NAME<br>Evans Funeral Chapel                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                            | ADDRESS<br>8800 Harbor Rd.                                   |                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H. H.                 |                                                                                     |                                                                                                                           |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP.

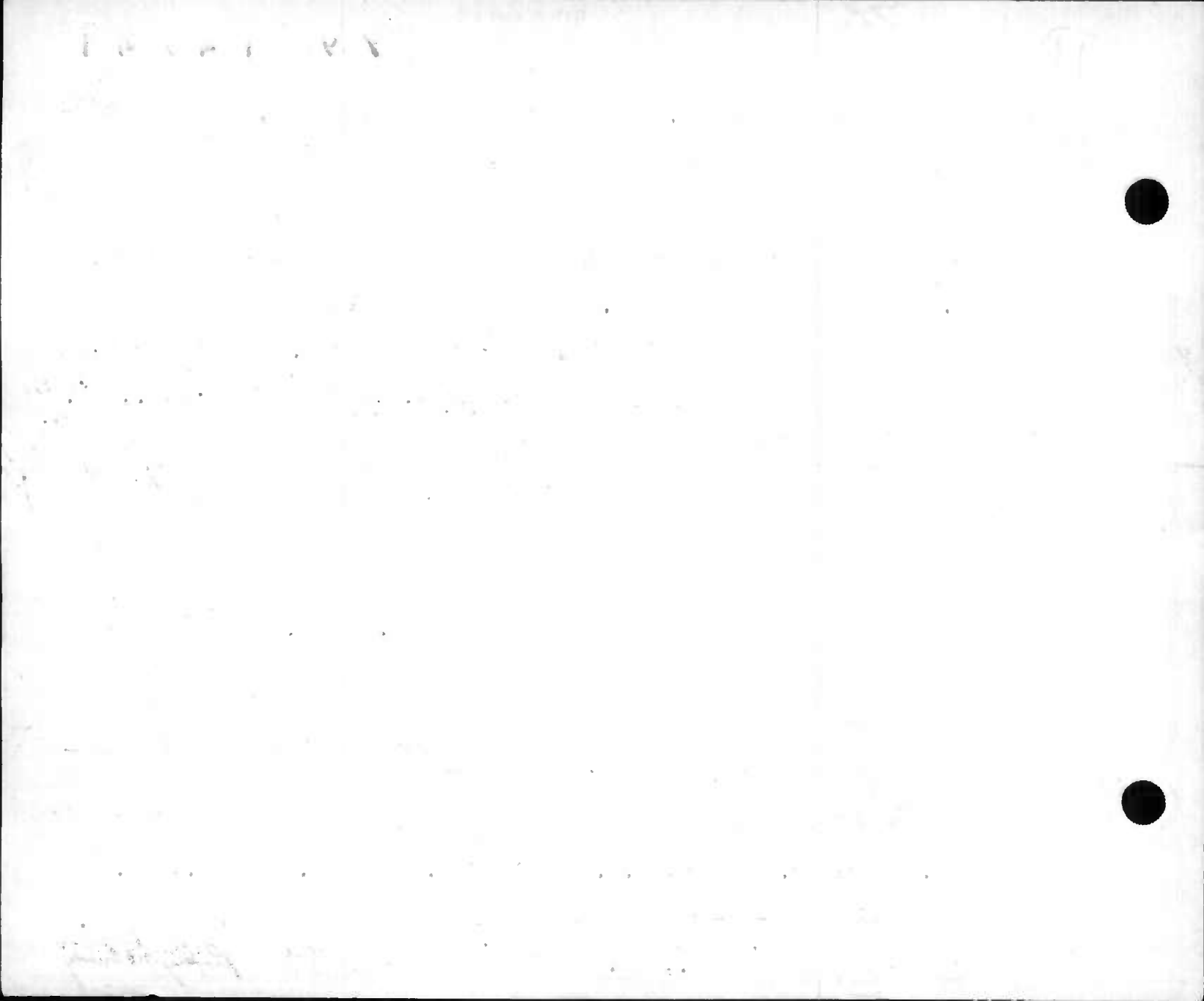
U. S. A. 1 8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                | REG. NO. 9 1 4 7 4 1 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margaret E. WEISKITTEL</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 21, 1979</b>                                                                                             |                                                                                                 |                                                                                                                            | 2b. HOUR<br><b>6<sup>10</sup> A M</b>                           |                                                                                |                      |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 30, 1900</b>                                                                                                     |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                                |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>            |                                                                                |                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                    |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>5100 Falls Road</b>                   |                                                                                |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Anton Weiskittel</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma W. Carmine</b>                                                                                 |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO<br><b>218-44-1333</b>                                                                                   |  | 17. INFORMANT ADDRESS<br><b>Francis A. Weiskittel Balto., Md.</b>                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>8 mos.</b> |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                               |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |                                                                                |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-5-</b> 19 <b>78</b> , to <b>6-21</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-20</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 22b. SIGNATURE OF PHYSICIAN<br><i>Alfred E. Ossman Jr.</i>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br><b>6-21-79</b>                              |                                                                                |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Alfred E. Ossman, M.D.</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  |                                                                                                                                                             | 22e. ADDRESS<br><b>1101 St. Paul St. Balto., Md.</b>                                                                                                 |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>6-23-79</b>                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                                                                                                    |                                                                                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>                               |                                                                                                                            |                                                                 |                                                                                |                      |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                                                                                  |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Richard A. Hardy</i>                                                                      |                                                                 |                                                                                |                      |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |                                                                                |                      |  |






 FOR  
1 - STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 4 2

REG. NO.

|                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                           |  |                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY J. WEISS<br>MIDDLE J. WEISS<br>LAST WEISS                                                                                                                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 26 79                                                                                                            |  | 2b. HOUR<br>5:30 PM                                                       |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>White                                                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 20 18                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS                                                                                                                                                                                                                                                                                          |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                    |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                    |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals                                                                                                                                                                                              |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                         |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                                               |  | 13c. CITY OR TOWN<br>Baltimore                                            |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                    |  | 13e. STREET ADDRESS<br>5427 Radecke Avenue                                                                                                                |  |                                                                           |  |
| 14. FATHER'S NAME<br>FIRST James MIDDLE Tinker LAST                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Rose MIDDLE MORAN LAST                                                                                                  |  |                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>212-10-6996                                                                                                                   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Bernard L. Weiss 5427 Radecke Ave.        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>5501<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bilateral necrotizing pneumonia</u> 3 wks<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Strangulated (R) inguinal hernia</u> 4 wks |  |                                                                                                                                                           |  |                                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                 |  |                                                                                                                                                           |  |                                                                           |  |
| 19a. DATE OF OPERATION<br>6/1/79                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Strangulated (R) inguinal hernia                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                         |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                     |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                  |  | 22a. DATE SIGNED<br>6/26/79                                                                                                                               |  |                                                                           |  |
| 22b. SIGNATURE<br>Kanter MD                                                                                                                                                                                                                                                                                                        |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KANTER                           |  |
| 22e. ADDRESS<br>Baltimore City Hosp                                                                                                                                                                                                                                                                                                |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                       |  |                                                                           |  |
| 23b. DATE<br>6-30-1979                                                                                                                                                                                                                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.                                                                                                                                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 28 1979                                                                                                              |  |                                                                           |  |
| 25b. REGISTRAR'S SIGNATURE<br>D. J. Brady                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                           |  |                                                                           |  |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

244125



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14743

1- FOR  
STATE  
REGISTER

|                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                       |                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>NANCY R. WELLER</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 17, 1979</b>                                     |                                                                                       | 2b. HOUR<br><b>6:10 P M</b>                                                                                                   |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>White</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 20, 1920</b>                                                                                                   |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS                                      |                                                                                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                      |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 | 13b. COUNTY<br><b>A.A.</b>                                                                                                                     | 13c. CITY OR TOWN<br><b>Pasadena</b>                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>313 Green Dr.</b>                                           |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George R. Rush</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Velma R. Humphreys</b>                                                                                  |                                                                                                 |                                                                                       |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>                                                                            | 17. INFORMANT<br><b>Mr. Robert C. Weller - Sec. 13.</b>                                                                                                     |                                                                                                 |                                                                                       |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pulmonary edema</b>                                                                                                |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                       |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                       |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1979</b> to <b>June 17, 1979</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>June 17, 1979</b> , and that in <del>my</del> <sup>my</sup> opinion death occurred on the date and hour and from the causes stated<br>above; (I) <del>was</del> <sup>did</sup> <del>not</del> view the body after death. |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                       |                                                                                                                               |
| 22b. SIGNATURE<br><b>Dr. L. L. Chandra</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                                 | 22c. DATE SIGNED<br><b>June 17/79</b>                                                 |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NISHA CHANDRA M.D.</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP. Bldg. MD 21205</b>                                                                                                   |                                                                                                 |                                                                                       |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                           | 23b. DATE<br><b>6-21-79</b>                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Mem Park</b>                                                                                                |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>S. Charleston Garrett Co. W. Va.</b> |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert J. Bonanco</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | ADDRESS<br><b>501 R. 101 in Park<br/>Savanna Park</b>                                                                                                       |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                   |                                                                                                                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



RECEIVED  
JUNE 17, 1973  
FBI - NEW YORK

NEW YORK CITY

THE NEW YORK HOSPITAL

100 WEST STREET, NEW YORK, N.Y. 10038

RE: [illegible]

DATE: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

FROM: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7 9 1 4 7 4 4

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WENGERD Edgar A. Wengerd</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-24-79</b>                  |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>528 PM</b>                                                                       |                                                                         |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>White</b>                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 05</b>                                                                                                        |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>                                                    |                                                                         | 7. IF UNDER YEAR<br>MONTHS DAYS HOURS MIN.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |                                                                         |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b>              |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>                                                                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                              |                                                                        | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                         | 13e. STREET ADDRESS<br><b>1934 Wareham Road</b>                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Wengerd</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Winifred Pittenger</b>                                                                                  |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>457-14-4474</b>                                                                                               |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Mildred I. Wengerd, Balto. MD 21222</b>                                                                                      |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                   |  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                 |                                                                         |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6/24 79 6/24 79</b>    |                                                                                                 |                                                                         |                                                                                                                            |  |
| 22a. I certify that (a) (this hospital) attended and deceased from <b>6/24 79</b> to <b>6/24 79</b> , that (b) (we) last saw the deceased alive on <b>6/24 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) did not view the body after death.                                                                                                       |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>C. HAMANN</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              | DEGREE                                                                 |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br><b>6/24/79</b>                                                              |                                                                         |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. HAMANN</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              | 22e. ADDRESS<br><b>4940 EASTERN AV.</b>                                |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                         |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              | 23b. DATE<br><b>6/28/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                       |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br>ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                | 25a. DATE REC'D BY REGISTRAR<br><b>JUN 28 1979</b>                                              |                                                                         |                                                                                                                            |  |

BP



*[Handwritten signature]*

2101 U.S. 500





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9

1 4 7 4 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Baby <b>EARL</b> Wesley                                                                                                                                                                                                                                                                                |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 15 79                                                  |                                                                                | 2b. HOUR<br>11:06 AM                                                                                                       |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>BLACK                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 79                                                                                                               |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>0 YRS 0 MONTHS 0 DAYS 2 HRS 51 MIN          |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE       | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY                                                                                                                                                                                                                                          |                                                                                                                                         | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2107 E. NORTH AVE.                                      |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>STANCIL MC NAIR                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LYVERNE WESTLY                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                                                 | 17. INFORMANT ADDRESS                                                                                                                                       |                                                                                                 |                                                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>severe prematurity / abortus</u><br>7627<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>charloamniotus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>       |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>26 51 min                                                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                 |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79                                                                                               |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/15</u> , 19 <u>79</u> , to <u>6/15</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><u>Mitchell B Cohen MD</u>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | DEGREE<br>MD                                                                                                                                                |                                                                                                 | 22c. DATE SIGNED<br>6/15/79                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mitchell B. Cohen                                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 22e. ADDRESS<br>Johns Hopkins Hosp 601 N Broadway Balt                                                                                                      |                                                                                                 |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 23b. DATE<br>6/16/79                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>JOHNS HOPKINS                                             |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MD                                                            |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | ADDRESS                                                                                                                                                     |                                                                                                 | 25a. DATE OF REGISTRATION<br>JUN 22 1979                                       |                                                                                                                            |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 7 4 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                              |                                                                                                           |                                                                                                                                                             |                                                                  |                                      |                                   |                 |  |                 |  |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------|-----------------------------------|-----------------|--|-----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)          |                                                                                                           | FIRST MIDDLE LAST                                                                                                                                           |                                                                  | 2a. DATE OF DEATH                    |                                   | MONTH DAY YEAR  |  | 7b. HOUR        |  |
| James WEST                                   |                                                                                                           |                                                                                                                                                             |                                                                  | June 7, 1979                         |                                   | 25              |  | AM              |  |
| 3. SEX                                       | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |  |
| MALE                                         | Black                                                                                                     | 2 15 26                                                                                                                                                     |                                                                  | 53 YRS.                              |                                   | MONTHS DAYS     |  | HOURS MIN.      |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                   |                 |  |                 |  |
| Md.                                          | USA                                                                                                       |                                                                                                                                                             |                                                                  | Baltimore City                       |                                   |                 |  | MD.             |  |
| 10. CITY OR TOWN OF DEATH                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                      | 12b. KIND OF BUSINESS OR INDUSTRY |                 |  |                 |  |
| Balto.                                       | Provident Hosp.                                                                                           |                                                                                                                                                             |                                                                  |                                      |                                   |                 |  |                 |  |

|                                                                                         |  |                          |  |                |  |                                                                     |  |                          |  |                     |  |
|-----------------------------------------------------------------------------------------|--|--------------------------|--|----------------|--|---------------------------------------------------------------------|--|--------------------------|--|---------------------|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13a. STATE               |  | 13b. COUNTY    |  | 13c. CITY OR TOWN                                                   |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS |  |
| Md.                                                                                     |  | Balto.                   |  |                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |                     |  |
| 14. FATHER'S NAME                                                                       |  | 15. MOTHER'S MAIDEN NAME |  |                |  |                                                                     |  |                          |  |                     |  |
| Edward West                                                                             |  | Virginia Madison         |  |                |  |                                                                     |  |                          |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT  |  | ADDRESS                                                             |  |                          |  |                     |  |
| No                                                                                      |  | 218-12-7272              |  | Audrey Trayham |  | 2132 E. Federal St.                                                 |  |                          |  |                     |  |

|                                                                                                                                                                                                                                                                                                      |  |                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>                                                                                                                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Hypertension</u> <u>Cardiomyopathy</u> <u>Cardiovascular Disease</u> |  |                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                 |  |                                                 |  |

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                |  |                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                   |  |
| 22a. I certify that (I (this hospital) attended the deceased from <u>May 9</u> , 19 <u>79</u> , to <u>June 7</u> , 19 <u>79</u> , that (I (we)) lost<br>saw the deceased alive on <u>June 7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I (we)) did not view the body after death. |  | 22b. SIGNATURE<br><u>[Signature]</u>                                   |  | DEGREE<br><u>M.D.</u>                                                          |  | 22c. DATE SIGNED                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS                                                           |  |                                                                                |  |                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                |  |                                                                   |  |

|                                              |  |                    |  |                                    |  |                                            |  |
|----------------------------------------------|--|--------------------|--|------------------------------------|--|--------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE          |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 6/11/79            |  | King Memorial Pk.                  |  | Baltimore Co., Md.                         |  |
| 24. FUNERAL DIRECTOR<br>NAME                 |  | ADDRESS            |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| Wm C March F/H                               |  | 1101 E. North Ave. |  | JUN 8 1979                         |  | <u>[Signature]</u>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 7 4 7  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                        |  |                                                                                                                                         |                                                       |                                                                                                                                                             |                            |                                                                                                 |  |
|----------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Russell Lowell West</b> |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 21 79</b> |                                                                                                                                                             | 2b. HOUR<br><b>5:45 AM</b> |                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                 |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 3 09</b>                                                                                                         |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cabinet Maker</b>                                                                    |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Carpentry</b>                                           |  |
| 13a. STATE<br><b>Maryland</b>                                                          |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                         |                                                       | 13c. CITY OR TOWN<br><b>Towson</b>                                                                                                                          |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>106 Center Ave. 21204</b>                                    |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbur Clarence West</b>                                                                   |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith May Jones</b>                                                                                     |                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>              |  |
| 16b. SOCIAL SECURITY NO.<br><b>521-03-2507</b>                                         |  | 17. INFORMANT<br><b>Maude E. West</b>                                                                                                   |                                                       | ADDRESS<br><b>106 Center Ave. Towson Md. 21204</b>                                                                                                          |                            | 18. DATE OF DEATH<br><b>6/21/79</b>                                                             |  |

|                                                                                                                                                            |  |                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arrhythmias Hypoxia</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 hours</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b>                                                                                                     |  | <b>2 weeks</b>                                                    |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myelocytic Leukemia</b>                                                                                     |  | <b>3 months</b>                                                   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/19</b> 19 <b>79</b> to <b>6/20</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/20</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Philip Kouts</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                        |  | DEGREE<br><b>BCRC</b>                                                                |  | 22c. DATE SIGNED<br><b>6/21/79</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip Kouts</b>                                                                                                                                                                                                                                                                                                     |  |                                                                        |  | 22e. ADDRESS<br><b>BCRC</b>                                                          |  |                                                                                                                               |  |

|                                                                                            |  |                             |  |                                                                                              |  |                                                   |  |
|--------------------------------------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                              |  | 23b. DATE<br><b>6-23-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Car. Cockeysville Balto Md.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd. 21212</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Philip Kouts</b> |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12/21/81



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5 FOR VITAL RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

REG. NO. 14748

1 - FOR  
STATE  
REGISTRAR

2543 BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

U. S. A. I. 1911

512

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 7 4 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                        |                                                                                                                                                                        |                                                                                                  |                                                                                      |                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>VIRGINIA M. WHEELEY</i>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        |                                                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 / 28 / 79</i>                                        |                                                                                      | 2b. HOUR<br><i>6:53 PM</i>                                                                                                            |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><i>White</i>                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 10 1905</i>                                                                                                                 |                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS HOURS MIN.<br><i>74</i>           |                                                                                                                                       |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD                     |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ST AGNES HOSPITAL</i> |                                                                                                                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Self-employed-retired</i> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Lamp Store</i>                                                                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><i>Maryland Baltimore Catonsville</i>                                                                                                                                                                                                                                                                                                                |                                                                                                                                        |                                                                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><i>2027 Old Frederick Rd. 21228</i>                           |                                                                                                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John H. Bowen</i>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Harcourt</i>                                                                                                  |                                                                                                  |                                                                                      |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><i>216-03-3295A</i>                                                                                                                        |                                                                                                  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Jane Maher, 6042 Moorehead Rd. 21228</i>         |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Pericarditis, acute</i><br><i>5308</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Gastrointestinal hemorrhage, acute</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Esophageal erosion &amp; possible varices</i>                                         |                                                                                                                                        |                                                                                                                                                                        |                                                                                                  |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        |                                                                                                                                                                        |                                                                                                  |                                                                                      |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                       |                                                                                                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>6:27 19 79</i>                                                                                                   |                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                 |                                                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                       |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>6/27 19 79</i> to <i>6/28 19 79</i> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <i>6/28 19 79</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death |                                                                                                                                        |                                                                                                                                                                        |                                                                                                  |                                                                                      |                                                                                                                                       |
| 22b. SIGNATURE<br><i>Joan Whitehouse M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                   |                                                                                                  | 22c. DATE SIGNED<br><i>6/29/79</i>                                                   |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JOAN WHITEHOUSE MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | 22e. ADDRESS<br><i>ST Agnes Hosp., W. L. Keno &amp; Caton Aves.</i>                                                                                                    |                                                                                                  |                                                                                      |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                        | 23b. DATE<br><i>7/2/79</i>                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Cemetery</i>                                |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dorsey, A.A. Maryland</i>                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>1630 Edmondson Ave., Baltimore, Md.<br/>Witzke Catonsville Funeral Home, P.A. 21228</i>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        |                                                                                                                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 3 1979</i>                                               |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                      |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a doctor.

BP







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14750

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARVEY</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | FIRST MIDDLE LAST<br><b>WHIT</b>                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 14, 1979</b>                                                                                                    |  | 2b. HOUR<br><b>3:14AM</b>                                                                                                  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Black</b>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 1 06</b>                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>73</b>                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hosp.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                           |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>425 N. Bradford Street</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Filler Watson</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Chaney Harvey</b>                                                                    |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-2708</b>                                                                                        |  | 17. INFORMANT ADDRESS<br><b>Carrie Williams 425 N. Bradford St.</b>                                                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG WITH METASTASIS</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                            |  |
| 22. I certify that (1) this hospital attended the deceased from <b>MAY 22, 1979</b> , to <b>JUNE 14, 1979</b> , that (1) we lost the deceased alive on <b>JUNE 14, 1979</b> , and that in my opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22a. SIGNATURE<br><b>W. Impagliatelli</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | DEGREE                                                                                                                                |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>6-14-79</b>                                                                                         |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALKER IMPAGLIATELLI, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 22d. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD</b>                                                     |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>6/18/79</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>                                                    |  |
| 24. FUNERAL DIRECTOR NAME<br><b>William C. March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

00111 11

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.BP  
DHMH - 16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  | REG. NO. 14751                                                                                                          |  |                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>SARA MAY WHITAKER</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>06-20-79</b>                                                                     |  | 2b. HOUR MIN.<br><b>9:50 P.</b> |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>WHITE</b>                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 25 96</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>82</b>                                            |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                                                |  | IF UNDER 24 HRS. HOURS MIN.                                                                                             |  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinal Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Gov't.</b>                                                                                   |  |                                                                                                                         |  |                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  | 13e. STREET ADDRESS                                                                                                     |  |                                 |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                     |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>301 McMechen St. #17</b>                                                                                         |  |                                                                                                                         |  |                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Eugene Grant</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bessie May Burgess</b>                                                                                     |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-0472</b>                                                                                                              |  | 17. INFORMANT ADDRESS<br><b>Mrs. Thomas deLauder Balto., Md.</b>                             |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC VASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |  |                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 22a. I certify that (this hospital) attended the deceased from <b>6/19</b> , 19 <b>79</b> , to <b>6/20</b> , 19 <b>79</b> , that (we) lost saw the deceased alive on <b>6/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.                                                |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 22b. SIGNATURE<br><b>Cesar G. Gamboa, MD</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |  | DEGREE<br><b>MD</b>                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>06-20-79</b>                                                                                     |  |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR G. GAMBOA, MD.</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  |                                                                                                                                                             |  | 22e. ADDRESS<br><b>% SINAL HOSPITAL</b>                                                      |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  | 23b. DATE<br><b>6-23-79</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                        |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b>                                                                    |  |                                                                                                                         |  |                                 |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                           |  |                                                                                                                         |  |                                 |  |
| 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |                                 |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |                                                              |                                                                                                                                                             |                                                                                      |                                                                               |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Soldie White</i>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>June 11, 1979</i>  |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><i>7 A.M.</i>                                                     |                                                                                                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>WHITE                                                                                                                           |                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>AUG. 1, 1896</i>                                                                                                   |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>82</i>              |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5715 PARK HTS. AVE., APT. 714 |                                                              |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                                                                                                                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |                                                              |                                                                                                                                                             |                                                                                      |                                                                               |                                                                                                                            |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 13b. COUNTY<br>BALTO.                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br>BALTO.                                                          |                                                                               |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SIMON HOFFMAN                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA UNKNOWN |                                                                                                                                                             |                                                                                      |                                                                               |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>061-52-3497                      |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>HAROLD LAMB 5912 KEY AVE. #21215                         |                                                                               |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br><i>4/40</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.H.D. - Cardiac failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i> |  |                                                                                                                                            |                                                              |                                                                                                                                                             |                                                                                      |                                                                               |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |                                                              |                                                                                                                                                             |                                                                                      |                                                                               |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |                                                              |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                               |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                               |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>6/4</i> 19 <i>79</i> to <i>present</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.                                                                                                                                                                            |  |                                                                                                                                            |                                                              |                                                                                                                                                             |                                                                                      |                                                                               |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Bernard Burgin M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |                                                              | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br><i>6/11/79</i>                                            |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARD BURGIN, M.D.                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                              | 22e. ADDRESS<br>3809 CLARKS LA. BALTO., MD 21215                                                                                                            |                                                                                      |                                                                               |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>JUNE 11, 1979                                                                                                                 |                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH DAVID                                                                                                            |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ELMONT L.I. NY                  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |                                                              | 25a. DATE REC'D. BY REGISTRAR<br>JUN 14 1979                                                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Barney McBrady</i>                           |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  | WHITE                                                                                                                                 |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  | 7 9 1 4 7 5 3<br>REG. NO.                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Judson White</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 5 79</b>                                                                                                        |  | 2b. HOUR<br><b>2:32</b> M                                                                                                  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>White</b>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 1 04</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Md. HSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Kennedysville</b> 13c. CITY OR TOWN <b>Kennedysville</b>                                                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>PO Box 101 Kennedysville, Md.</b>                                                                                                 |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>J</b> LAST <b>White Sr.</b>                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE <b>P</b> LAST <b>Parles</b>                                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>218 10 8639</b>   |  |                                                                                                                            |  |
| 17. INFORMANT<br><b>Chart</b>                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br><b>Hospital Records</b>                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>3940<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Post Mitral commissurotomy (open)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Removal of thrombus from left atrium</b>                     |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>5/31/79</b>                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Mitral stenosis</b>                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/5</b> 19 <b>79</b> , to <b>6.5</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6.5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Abdulla Attum</b>                                                                                                                                                                                                                                                                                                                          |  | DEGREE<br><b>Attum</b>                                                                                                                |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Abdulla Attum</b>                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br><b>Univ. of Md. HSP</b>                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>6/7/79</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Still Pond Cemetery</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Still Pond, Md.</b>                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. William Wells</b>                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br><b>Chestertown, Md.</b>                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1979</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony K. ...</b>                                                                        |  |

U C N P I V N



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 5 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lenora T White</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 30 19</b>                              |                                                                                | 2b. HOUR<br><b>5P. M</b>                                                                                                   |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>W</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 1, 1884</b>                                                                                                   |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA - Md.</b>                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>              |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b> |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>garment</b>                                                                        |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                          |                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS<br><b>3433 Ravenwood Ave. 21213</b>                            |                                                                                |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph T Tarleton</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther Shrieves</b>                                                                                     |                                                                                    |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>unknown</b>                                                                                                                  |                                                                                    | 17. INFORMANT<br><b>Rossie White Baltimore, Md.</b>                            |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>atherosclerotic Cardiovascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>chronic Organic Brain Syndrome Cachexia Ulcer of W Foot</b>                                                                                                                                                                                     |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                             |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 24</b> 19 <b>79</b> to <b>June 30</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>June 30</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                            |
| 22a. SIGNATURE<br><b>Eva Maber MD</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                             | DEGREE<br><b>MD.</b>                                                                                                                                        |                                                                                    | 22c. DATE SIGNED<br><b>6/30/79</b>                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EVA MABER MD</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             | 22e. ADDRESS<br><b>Union Memorial Hospital</b>                                                                                                              |                                                                                    |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                              | 23b. DATE<br><b>7/3/79</b>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery Chance Son Md.</b>                                                                             |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy Webster</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | ADDRESS<br><b>Rt. 3, Box 354 Princess Anne, Md.</b>                                                                                                         |                                                                                    | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUL 6 1979</b>                           |                                                                                                                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                             |                                                                                          |                                                            |                                                                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                             |  | 7 9 1 4 7 5 5                                                                                                            |                                                                    |                                                                                                                                                            |                                                                                             | REG. NO.                                                                                 |                                                            |                                                                                                                                                |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Vivian R. White                                                                                                                                                                                                                                                                |  |                                                                                                                          |                                                                    |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br>June 8, 1979                                             |                                                                                          |                                                            | 2b HOUR<br>2 P M                                                                                                                               |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>White                                                                                                          |                                                                    | 5 DATE OF BIRTH MONTH DAY YEAR<br>November 28, 1915                                                                                                        |                                                                                             | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>63                                                |                                                            | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                                   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                       |                                                                    | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                |                                                            |                                                                                                                                                |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |                                                                    |                                                                                                                                                            |                                                                                             | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>valet parking supervisor |                                                            | 12b KIND OF BUSINESS OR INDUSTRY                                                                                                               |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br>Md P. G. Laurel                                                                                                                                                                                            |  |                                                                                                                          |                                                                    |                                                                                                                                                            | 13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                          | 13c STREET ADDRESS<br>45 A Street                          |                                                                                                                                                |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Robert White                                                                                                                                                                                                                                                                                  |  |                                                                                                                          |                                                                    |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nola Edmondson                                 |                                                                                          |                                                            |                                                                                                                                                |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                              |  |                                                                                                                          | 16b SOCIAL SECURITY NO<br>220 05 2417                              |                                                                                                                                                            | 17 INFORMANT ADDRESS<br>Irene L. White same as 13 above                                     |                                                                                          |                                                            |                                                                                                                                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD, Rheumatic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                             |                                                                                          |                                                            |                                                                                                                                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Myocardial degeneration, Atrial fibrillation</u>                                                                                                                                           |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                             |                                                                                          |                                                            |                                                                                                                                                |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  |                                                                                                                          | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                            |                                                                                             | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |                                                            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                   |  |                                                                                                                          | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                                                             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |                                                            |                                                                                                                                                |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                               |  |                                                                                                                          | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                                             | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                            |                                                            |                                                                                                                                                |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Oct 1974</u> to <u>June 1 1979</u> that (I) (we) lost <u>above</u> (I) (we) (did) and not view the body after death.                                                                                                                                           |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                             |                                                                                          |                                                            |                                                                                                                                                |  |
| 22b SIGNATURE DEGREE<br>Robert Deitz                                                                                                                                                                                                                                                                                                |  |                                                                                                                          |                                                                    |                                                                                                                                                            | 22c DATE SIGNED                                                                             |                                                                                          |                                                            | 22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Deitz                                                                                                                                                                                                                                                                                |  |                                                                                                                          |                                                                    |                                                                                                                                                            | 22f ADDRESS                                                                                 |                                                                                          |                                                            |                                                                                                                                                |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                  |  |                                                                                                                          | 23b DATE<br>June 11, 1979                                          |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br>Savage Cemetery                                        |                                                                                          | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Savage, Maryland |                                                                                                                                                |  |
| 24 FUNERAL DIRECTOR NAME<br>Donaldson Funeral Home, Laurel, Md                                                                                                                                                                                                                                                                      |  |                                                                                                                          |                                                                    |                                                                                                                                                            | 25a DATE REC'D. BY REGISTRAR<br>JUN 15 1979                                                 |                                                                                          | 25b REGISTRAR'S SIGNATURE                                  |                                                                                                                                                |  |

CCNY 1 2 3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14756

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|-----------|---------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------|--|
| 1. STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Walter B. White                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| 2a. DATE KNOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                |  | MONTH DAY YEAR                                                                                          |           | 2b. HOUR                  |                                                                     |                                                                     |                                                                               |                                         |  |
| ESTIMATED                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6 22 19 79                                                                                              |           | M                         |                                                                     |                                                                     |                                                                               |                                         |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                 |           | 5. DATE OF BIRTH          |                                                                     | 6. AGE (IN YEARS)                                                   |                                                                               | IF UNDER 1 YR.                          |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | black                                                                                                   |           | MONTH DAY YEAR<br>4 01 06 |                                                                     | LAST BIRTHDAY<br>73 YRS.                                            |                                                                               | MONTHS DAYS HOURS MIN                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |           | 8. MARRIED                |                                                                     | NEVER MARRIED                                                       |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH    |  |
| Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | USA                                                                                                     |           | WIDOWED                   |                                                                     | DIVORCED                                                            |                                                                               | Baltimore City MD.                      |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |           |                           |                                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY       |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 1123 N. Parrish Street                                                                                  |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                             |           | 13c. CITY OR TOWN         |                                                                     | 13d. INSIDE CITY LIMITS?                                            |                                                                               | 13e. STREET ADDRESS                     |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                         |           | Baltimore                 |                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                               | 1123 N. Parrish St.                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                         |           |                           | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |                                                                     |                                                                               |                                         |  |
| HARRY WHITE                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                         |           |                           | MARY E. BESS                                                        |                                                                     |                                                                               |                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                         |           |                           | 16b. SOCIAL SECURITY NO.                                            |                                                                     | 17. INFORMANT ADDRESS                                                         |                                         |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                         |           |                           | 217-01-9616                                                         |                                                                     | VIOLA CALDWELL 1100 Penna. Ave. Apt. 1209                                     |                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) }<br>DUE TO, OR AS A CONSEQUENCE OF (c) }                                                                                        |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                    |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                         |           |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |                                                                     |                                                                               |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                         |           |                           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                     |                                                                               |                                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                         |           |                           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         |           |                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                                                                                         |           |                           |                                                                     |                                                                     |                                                                               |                                         |  |
| ACTUAL SIGNATURE <i>H. Guard</i>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                         |           |                           | TITLE (SPECIFY) Assistant                                           |                                                                     |                                                                               | DATE SIGNED 6/24/79                     |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                         |           |                           | ADDRESS 111 Penn Street, Baltimore, MD 21201                        |                                                                     |                                                                               |                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                         | 23b. DATE |                           | 23c. NAME OF CEMETERY OR CREMATORY                                  |                                                                     |                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                         | 6/28/79   |                           | MT. CALVARY CEM.                                                    |                                                                     |                                                                               | ANNE ARUNDEL CO. MD.                    |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                         |           |                           | 25a. DATE REC'D. BY REGISTRAR                                       |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                    |                                         |  |
| Wm. C. March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                         |           |                           | JUN 26 1979                                                         |                                                                     | <i>Robert McElroy</i>                                                         |                                         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9

14757

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                |                                                                                                                                                            |                                                                               |                                                                                     |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM Edward WHITE                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 29 79<br>2b. HOUR<br>10-20 P.M.      |                                                                                     |                                                                                                                            |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4 RACE<br>Negro                                                                                                                | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 1 1918                                                                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61<br>YRS.                                  |                                                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD. BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |                                                                                     |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MONTEBELLO CENTER |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BRICKLAYER |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Co.                                                                             |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                |                                                                                                                                                            | 13b COUNTY<br>Baltimore                                                       | 13c CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM E WHITE                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>VIRGINIA TROGDON             |                                                                                     |                                                                                                                            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 2                                                                                           | 17. INFORMANT<br>ADDRESS<br>Mrs. Sylvia Johnson 1327 Homestead St.            |                                                                                     |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u><br><u>3485</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>CEREBRAL EDEMA &amp; ACTIVE PULMONARY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>TUBERCULOSIS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4-19-79 TO 6-29-79</u> |                                                                                                                                |                                                                                                                                                            |                                                                               |                                                                                     |                                                                                                                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>SEIZURE DISORDER and CHRONIC ALCOHOLISM</u>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                |                                                                                                                                                            |                                                                               |                                                                                     |                                                                                                                            |
| 19a DATE OF OPERATION<br><u>11-29-78</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>SUBDURAL hematoma from SKULL FX</u>                                                                  |                                                                               | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-2-</u> <u>19-79</u> , to <u>6-29-19-79</u> , that (I) (we) last saw the deceased alive on <u>6-29-79</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                                                                                                                                            |                                                                                                                                |                                                                                                                                                            |                                                                               |                                                                                     |                                                                                                                            |
| 22b SIGNATURE<br><u>P. RAJARAM, MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                | DEGREE<br>MD.                                                                                                                                              |                                                                               | 22c. DATE SIGNED<br><u>6-29-79</u>                                                  |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>P. RAJARAM, MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                | 22e ADDRESS<br><u>Montebello center</u><br><u>BALTIMORE, MD - 21218</u>                                                                                    |                                                                               |                                                                                     |                                                                                                                            |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | 23b DATE<br><u>7-5-79</u>                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Balto. National Cmt.</u>             |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Md.</u>                                                         |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Randolph J. Collick</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | ADDRESS<br><u>2431 E. Oliver St.</u>                                                                                                                       |                                                                               | 25a DATE REC'D. BY REGISTRAR<br><u>JUL 2 1979</u>                                   | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                            |



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

14151

|                   |                                                           |                                                           |                                                           |
|-------------------|-----------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------|
| NAME              | WILLIAM                                                   | EDWARD                                                    | WHITE                                                     |
| DATE              | 10/10/75                                                  | 10/10/75                                                  | 10/10/75                                                  |
| SEX               | MALE                                                      | MALE                                                      | MALE                                                      |
| AGE               | 40                                                        | 40                                                        | 40                                                        |
| HEIGHT            | 5'10"                                                     | 5'10"                                                     | 5'10"                                                     |
| WEIGHT            | 170                                                       | 170                                                       | 170                                                       |
| HAIR              | BROWN                                                     | BROWN                                                     | BROWN                                                     |
| EYES              | BROWN                                                     | BROWN                                                     | BROWN                                                     |
| TEETH             | GOOD                                                      | GOOD                                                      | GOOD                                                      |
| SCARS             | NONE                                                      | NONE                                                      | NONE                                                      |
| MARKS             | NONE                                                      | NONE                                                      | NONE                                                      |
| HOBBIES           | SPORTS                                                    | SPORTS                                                    | SPORTS                                                    |
| RELIGION          | CATHOLIC                                                  | CATHOLIC                                                  | CATHOLIC                                                  |
| EDUCATION         | HIGH SCHOOL                                               | HIGH SCHOOL                                               | HIGH SCHOOL                                               |
| OCCUPATION        | TECHNICAL                                                 | TECHNICAL                                                 | TECHNICAL                                                 |
| RESIDENCE         | 1234 MAIN ST                                              | 1234 MAIN ST                                              | 1234 MAIN ST                                              |
| CITY              | NEW YORK                                                  | NEW YORK                                                  | NEW YORK                                                  |
| STATE             | NY                                                        | NY                                                        | NY                                                        |
| COUNTRY           | USA                                                       | USA                                                       | USA                                                       |
| DATE OF BIRTH     | 10/10/35                                                  | 10/10/35                                                  | 10/10/35                                                  |
| DATE OF DEATH     | NONE                                                      | NONE                                                      | NONE                                                      |
| DATE OF INTERVIEW | 10/10/75                                                  | 10/10/75                                                  | 10/10/75                                                  |
| INTERVIEWER       | JOHN DOE                                                  | JOHN DOE                                                  | JOHN DOE                                                  |
| WITNESSES         | JANE DOE                                                  | JANE DOE                                                  | JANE DOE                                                  |
| REMARKS           | ALL INFORMATION OBTAINED FROM SOURCE IS TRUE AND CORRECT. | ALL INFORMATION OBTAINED FROM SOURCE IS TRUE AND CORRECT. | ALL INFORMATION OBTAINED FROM SOURCE IS TRUE AND CORRECT. |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 7 5 8

|                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             |                                                                               |                                                                                                 |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SARAH C. WHITEHEAD                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/15/79                                |                                                                                                 | 2b. HOUR<br>1:00 PM                          |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                              | 4. RACE<br>Black                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 27 25                                                                                                              |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS                                                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. MD.                                              |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. MD HOSP. BALTO. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                              |                                                                                                                                    | 13b. COUNTY<br>BALTO                                                                                                                                        | 13c. CITY OR TOWN<br>BALTO                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK                                                                                                                                                                                                                                                                               |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LILLIE BROWN                                                                                               |                                                                               | 13e. STREET ADDRESS<br>437 MANSE CT.                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                    |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>220 208556                                                                                                                      |                                                                               | 17. INFORMANT<br>ADDRESS<br>Sharon Whitehead                                                    |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY<br>(IMMEDIATE CAUSE (a)) 1749 GRAM NEGATIVE SEPSIS / HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) IMMUNOSUPPRESSION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) METASTATIC BREAST CARCINOMA                   |                                                                                                                                    |                                                                                                                                                             |                                                                               |                                                                                                 |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>HYPOXIA / RENAL FAILURE                                                                                                                                                                    |                                                                                                                                    |                                                                                                                                                             |                                                                               |                                                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                     |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY, 19 79, to JUNE 15, 19 79, that (I) (we) lost<br>saw the deceased alive on JUNE 15, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                    |                                                                                                                                                             |                                                                               |                                                                                                 |                                              |
| 22b. SIGNATURE<br>Michael Bergman MD                                                                                                                                                                                                                                                                                          |                                                                                                                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                                                                               | 22c. DATE SIGNED<br>6/15/79                                                                     |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL BERGMAN MD                                                                                                                                                                                                                                                                   |                                                                                                                                    | 22e. ADDRESS<br>BCRC - UNIV. OF MD HOSPITAL                                                                                                                 |                                                                               |                                                                                                 |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                        | 23b. DATE<br>6-18-79                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn                                                                                                            |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD.                                        |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>William C. Brown 1206-08 W. North Ave.                                                                                                                                                                                                                                                |                                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>JUN 21 1979                                                                                                                |                                                                               | 25b. REGISTRAR'S SIGNATURE<br>Hickey McBrady                                                    |                                              |

6 2 1 1 1 1 1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 5 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                                                                                                                            |                                                                                     |                                                                                     |                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>JANE REBECCA WHITLOCK</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br><b>June 19, 1979</b>                             |                                                                                     | 2b HOUR<br>M                                                                                                              |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4 RACE<br><b>White</b>                                                                    | 5 DATE OF BIRTH<br><b>April 15, 1923</b>                                                                                                                   |                                                                                     | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>56</b>                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                      | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                              | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                        |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                             | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Baltimore City Hospitals</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                                                           |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           | 13b COUNTY                                                                                                                                                 | 13c CITY OR TOWN<br><b>Baltimore</b>                                                | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>1102 Armistead Way</b>                                                                           |
| 14 FATHER'S NAME<br><b>George</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                           | 15 MOTHER'S MAIDEN NAME<br><b>Maria</b>                                                                                                                    |                                                                                     | ADDRESS<br><b>Mr. George L. Whitlock, Sr. 1102 Armistead Way</b>                    |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           | 16b SOCIAL SECURITY NO.<br><b>215-12-4418</b>                                                                                                              |                                                                                     | 17 INFORMANT<br><b>Mr. George L. Whitlock, Sr.</b>                                  |                                                                                                                           |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6w.</b> |                                                                                           |                                                                                                                                                            |                                                                                     |                                                                                     |                                                                                                                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes mellitus</b>                                                                                                                                                                                                                                                                                           |                                                                                           |                                                                                                                                                            |                                                                                     |                                                                                     |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                  |                                                                                           | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                 |                                                                                           | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                               |                                                                                           |                                                                                                                                                            |                                                                                     |                                                                                     |                                                                                                                           |
| 22b SIGNATURE<br><i>Michael T. Rudikoff</i>                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                                     | 22c DATE SIGNED                                                                     |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael T. Rudikoff, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           | 22e ADDRESS<br><b>222 W. Coldspring Lane</b>                                                                                                               |                                                                                     |                                                                                     |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                             | 23b DATE<br><b>6-22-1979</b>                                                              | 23c NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                               | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |                                                                                     |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                                                                                                                            | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>                                  | 25b REGISTRAR'S SIGNATURE<br><i>P. J. [Signature]</i>                               |                                                                                                                           |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14760

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           |                                                                                                                                                            |                                                                    |                                                                                                |                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ida M.C. Whitted</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 22 79</b>               |                                                                                                | 2b HOUR<br>M<br><b>AM</b>                                                                                                 |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                 | 4 RACE<br><b>Black</b>                                                                                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 20 16</b>                                                                                                        |                                                                    | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                               |                                                                                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                                                | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2727 W. Garrison Ave.</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                           | 13b COUNTY                                                                                                                                                 | 13c CITY OR TOWN<br><b>Balto.</b>                                  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>2727 W. Garrison Ave</b>                                                                         |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Chambers</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ida</b>                                                                                            |                                                                    |                                                                                                |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                           | 16b SOCIAL SECURITY NO.<br><b>237-20-7164</b>                                                                                                              | 17 INFORMANT<br>ADDRESS<br><b>Mary Downs 2727 W. Garrison Ave.</b> |                                                                                                |                                                                                                                           |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio - Pulmonary Arrest</b><br><b>1552</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Metastatic Liver Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Failure</b> |                                                                                                                                           |                                                                                                                                                            |                                                                    |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                    |                                                                                                                                           |                                                                                                                                                            |                                                                    |                                                                                                |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                           | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                    | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                   |                                                                                                                                           | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                    | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               |                                                                                                                                           | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                    | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>79</b> , to <b>5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                           |                                                                                                                                           |                                                                                                                                                            |                                                                    |                                                                                                |                                                                                                                           |
| 22b SIGNATURE<br><b>Eugene Lundy</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                    | 22c DATE SIGNED<br><b>6/25/79</b>                                                              |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eugene Lundy MD</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           | 22e ADDRESS<br><b>3100 Wyman Park Dr Baltimore Maryland</b>                                                                                                |                                                                    |                                                                                                |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                              | 23b DATE<br><b>6/27/79</b>                                                                                                                | 23c NAME OF CEMETERY OR CREMATORY<br><b>Town Cem.</b>                                                                                                      |                                                                    | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hillsboro, N.C.</b>                            |                                                                                                                           |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                       |                                                                    | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                             | 25b REGISTRAR'S SIGNATURE<br><b>L. H. Kelly</b>                                                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00118



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 6 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                           |                                                                                                 |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELWOOD C WILDERSON                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 28, 1979                                      |                                                                                                 | 2b. HOUR<br>8:52A <sup>M</sup>                                 |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                 | 4 RACE<br>White                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 25, 1905                                                                                                        |                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74<br>YRS.                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                                |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Service Station Owner |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ret.                      |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. CITY OR TOWN<br>Pikesville                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elwood C. Wilderson, Sr.                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maude Smith                              |                                                                                                 |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                    |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>none                                                                                                                            |                                                                                           | 17. INFORMANT<br>Mrs. Veronica Wilderson                                                        |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 213-01-1341 A                                                                                                                                               |                                                                                           | 800 Judy Lane Pikesville, Md. 21208                                                             |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RUPTURED ABD ANEURYSM</u><br><u>4413</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                         |                                                                                                                                                             |                                                                                           |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CHRONIC RENAL FAILURE</u>                                                                                                                                                                                                           |                                                                                                                                         |                                                                                                                                                             |                                                                                           |                                                                                                 |                                                                |
| 19a. DATE OF OPERATION<br><u>6/22</u>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>RENAL FAILURE</u>                                                                                    |                                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             |                                                                                           |                                                                                                 |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                     |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/22</u> , 19 <u>79</u> , to <u>6/28</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.      |                                                                                                                                         |                                                                                                                                                             |                                                                                           |                                                                                                 |                                                                |
| 22b. SIGNATURE<br><u>R O BUNNAN MD</u>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | DEGREE                                                                                                                                                      |                                                                                           | 22c. DATE SIGNED<br><u>6/29/79</u>                                                              |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R O BRENWAN MD</u>                                                                                                                                                                                                                                                                                                                |                                                                                                                                         | 22e. ADDRESS<br><u>JOHN'S HOPKINS HOSP</u>                                                                                                                  |                                                                                           |                                                                                                 |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Entombed</u>                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 23b. DATE<br><u>6/30/79</u>                                                                                                                                 |                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Maus.</u>                                  |                                                                |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Pikesville Baltimore Md.</u>                                                                                                                                                                                                                                                                                                 |                                                                                                                                         |                                                                                                                                                             |                                                                                           |                                                                                                 |                                                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Loring Byers Funeral Directors, P.A.</u><br><u>8728 Liberty Road Randallstown, Md. 21133</u>                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                             |                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><u>JUL 3 1979</u>                                              |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                           | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>                                           |                                                                |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF JUSTICE

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U.S. DEPARTMENT OF JUSTICE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14762

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                       |  | FOR                                                                                                     |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2a DATE KNOWN OF DEATH                                                                                  |  |
| Mack J. Wiley                                                                                                                                                                                                                                                                                                                                                                                                                            |  | MONTH DAY YEAR                                                                                          |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 2b HOUR                                                                                                 |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | M                                                                                                       |  |
| 4 RACE                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 2c DATE PRONOUNCED DEAD                                                                                 |  |
| Black                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | MONTH DAY YEAR                                                                                          |  |
| 5 DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2d HOUR                                                                                                 |  |
| MONTH DAY YEAR                                                                                                                                                                                                                                                                                                                                                                                                                           |  | M                                                                                                       |  |
| 10 6 06                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10:01                                                                                                   |  |
| 6 AGE (IN YEARS)                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                |  |
| LAST BIRTHDAY                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?                                                                             |  |
| 72 YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | USA                                                                                                     |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                     |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                       |  | Baltimore City, MD.                                                                                     |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 1811 N. Duncan Street                                                                                   |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                                                                             |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                         |  |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b COUNTY                                                                                              |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Balto.                                                                                                  |  |
| 13c CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13d INSIDE CITY LIMITS?                                                                                 |  |
| 1811 Duncan St.                                                                                                                                                                                                                                                                                                                                                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                                |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                        |  | FIRST MIDDLE LAST                                                                                       |  |
| Jim Wiley                                                                                                                                                                                                                                                                                                                                                                                                                                |  | Annie Brown                                                                                             |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                        |  | 16b SOCIAL SECURITY NO.                                                                                 |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 705-10-9396                                                                                             |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                 |  |
| Geneva Johnson                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 1811 Duncan St.                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                            |  |
| PART I DEATH WAS CAUSED BY                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                         |  |
| IMMEDIATE CAUSE (a) Carcinoma of Colon                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                         |  |
| 1539                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                         |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                         |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                         |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                                                                                                         |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                         |  |
| 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                         |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                         |  |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | HOUR A.M. MONTH DAY YEAR                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | P.M. 19                                                                                                 |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                                            |  | 21d. INJURY OCCURRED                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                       |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                                              |  | 21f. LOCATION                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | STREET CITY OR TOWN COUNTY STATE                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                                                                                         |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |  | TITLE (SPECIFY)                                                                                         |  |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |  | Assistant MEDICAL EXAMINER                                                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |  | DATE SIGNED                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6/10/79                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE                                                                                               |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 6/14/79                                                                                                 |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                                                                                                                       |  | 23d. LOCATION                                                                                           |  |
| King Memorial Pk.                                                                                                                                                                                                                                                                                                                                                                                                                        |  | CITY OR TOWN COUNTY STATE                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Baltimore Co., Md.                                                                                      |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR                                                                           |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                                              |  |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                        |  | JUN 12 1979                                                                                             |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14763

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                 |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN E. WILHELM</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 14 79</b>               |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>720 AM</b>                                                                       |                                                                 |                                                                                                                            |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>WHITE</b>                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/16/09</b>                                                                                                        |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                               |                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                        |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                                                        |                                                                        | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                                                                                          |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS<br><b>6117 STANTON AVE</b>                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>          |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-03-3780</b>                                                      |                                                                        | 17. INFORMANT<br><b>WIFE</b>                                                                                                                                |                                                                                | ADDRESS<br><b>SAME</b>                                                                          |                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>CARDIAC FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DISSEMINATED CA OF COLON</b> |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 MINUTES</b><br><b>DAYS</b><br><b>YEARS</b>                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                 |                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 8</b> , 19 <b>79</b> , to <b>JUNE 14</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>JUNE 14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Donato A. Sisto</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | DEGREE<br><b>M.D.</b>                                                          |                                                                                                 |                                                                 | 22c. DATE SIGNED<br><b>JUNE 14/79</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONATO SISTO</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>                                          |                                                                                                 |                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF CREMATION, GIVE CITY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    | 23b. DATE<br><b>6/16/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>                     |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO, MD.</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Paul E. Chenoweth</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                            |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia M. Brady</b>          |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315

JOHN E. WELLES  
1st Lt  
Branch of Service  
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REGIMENT  
ARTILLERY  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |                                                       |                                                                                                                                                             |                             |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Luke Wilhelm</u>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>6/17/79</u> |                                                                                                                                                             | 2b. HOUR<br><u>12:15 PM</u> |                                                                                                                            |  |
| 3. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><u>White</u>                                                                                                                      |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>11/10/02</u>                                                                                                       |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><u>77</u>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MD.</u>                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                                                                                  |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTO CITY</u> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTO</u>                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>FEDERAL Hill Nrsng. Home</u> |                                                       |                                                                                                                                                             |                             | 12. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>RETIRED</u>                                          |  |
| 13a. STATE<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><u>BALTO</u>                                                                                                                  |                                                       | 13c. CITY OR TOWN<br><u>BALTO</u>                                                                                                                           |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>HERMAN J. WILHELM</u>                                                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><u>MARY DYER</u>                                                                                  |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>YES</u>                                              |                             | 16b. SOCIAL SECURITY NO.<br><u>216-01-2946</u>                                                                             |  |
| 17. INFORMANT<br>ADDRESS<br><u>3906 W. 176 COURT</u>                                                                                                                                                                                                                                                                                                                                                                         |  | 18. NAME OF INFORMANT<br><u>NANCY KLEINE</u>                                                                                                 |                                                       | 19. ADDRESS<br><u>TORRANCE CAFE</u>                                                                                                                         |                             | 20. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u>                                                    |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Atherosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                              |                                                       |                                                                                                                                                             |                             |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Organic brain syndrome</u>                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                       |                                                                                                                                                             |                             |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>                                                                            |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                             |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                             |                                                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> 19 <u>78</u> , to <u>6/17</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/17</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                 |  |                                                                                                                                              |                                                       |                                                                                                                                                             |                             |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>J. P. KAMMANT</u>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |                                                       | DEGREE<br><u>M.D.</u>                                                                                                                                       |                             | 22c. DATE SIGNED<br><u>6/18/79</u>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. P. KAMMANT</u>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                       | 22e. ADDRESS<br><u>124 Wall St. Balt., Md. 21230</u>                                                                                                        |                             |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>CREMATION</u>                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><u>6-19-79</u>                                                                                                                  |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><u>WESTVIEW MEM.</u>                                                                                                  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO. CO. MD</u>                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Harley F.H. G6601 FRED AVE</u>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 19 1979</u>                                                                                                         |                             | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCurdy</u>                                                                         |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

POINT 88

NO. 10 IN SEQUENCE



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POINT 88

Items 7a, 7b, 8532 6/19/79 83

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14765

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                         |                                                               |                                                                                                   |                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Jerry Wilkenson                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                               |                                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 2 79<br>M            |                                                                                                   |                                                                                                 |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                              | 4 RACE<br>Black                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 11 04                                                                                                           |                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |                                                                                                 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>unknown                                                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                          |                                                                                                 |
| 10 CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1100 Penna. Ave. |                                                                                                                                                         |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                  |                                                                                                 |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                               |                                                                                                                                                         | 13b. COUNTY                                                   | 13c. CITY OR TOWN<br>Balto.                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Wilkenson                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               |                                                                                                                                                         | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Smith |                                                                                                   |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>212-14-2148                                                                                                                 |                                                               | 17 INFORMANT ADDRESS<br>Elizabeth Grant 1100 Lynhurst St.                                         |                                                                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>probable myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                               |                                                                                                                                                         |                                                               |                                                                                                   |                                                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Diabetes mellitus</u>                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                         |                                                               |                                                                                                   |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                        |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |                                                                                                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                                                                                                                               |                                                                                                                                                         |                                                               |                                                                                                   |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                              |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                  |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                 |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> 19 <u>78</u> to <u>6/5/81</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                               |                                                                                                                               |                                                                                                                                                         |                                                               |                                                                                                   |                                                                                                 |
| 22b. SIGNATURE<br><u>Judy Stone, MD</u>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                               |                                                                                                                                                         |                                                               | 22c. DATE SIGNED<br>6/4/79                                                                        |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Judy Stone                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                               |                                                                                                                                                         |                                                               | 22e. ADDRESS<br>Maryland General Hospital                                                         |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                               | 23b. DATE<br>6/7/79                                                                                                                                     |                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                                             |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                               |                                                                                                                                                         |                                                               |                                                                                                   |                                                                                                 |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                               |                                                                                                                                                         |                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1979                                                       |                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                         |                                                               | 25b. REGISTRAR'S SIGNATURE<br><u>Henry H. Brady</u>                                               |                                                                                                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Mrs SOPHIE N. WILKOWSKI

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

6

19

1201 P.

3. SEX

F

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

9

30

15

6. AGE (IN YEARS LAST BIRTHDAY)

63

YRS

MONTHS

DAYS

HOURS

MINS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

CHURCH HOSPITAL

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

HOME MAKER

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE  
MARYLAND

13c. COUNTY

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

411 S. CHESTER ST.

14. FATHER'S NAME

STANLEY MIEDZIELSKI

15. MOTHER'S MAIDEN NAME

AGNES TOPUREK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

212 09 8273

17. INFORMANT

MR. FRED WILKOWSKI 411 S. CHESTER

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

3352

IMMEDIATE CAUSE (a)

Pseudo BULBAR PALSY

DUE TO, OR AS A CONSEQUENCE OF

(b)

DYSPHAGIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

CARDIAC ARREST

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

6/2 GASTROSTOMY

19a. DATE OF OPERATION

6/2/69

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Dysphagia

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Somppall

DEGREE

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SOMPPALL

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

6-12-1979

23c. NAME OF CEMETERY OR CREMATORY

SAC. HEART OF JESUS

23d. LOCATION  
CITY OR TOWN

BALTIMORE

COUNTY

STATE  
MD.24. FUNERAL DIRECTOR  
NAME

RAYMOND L. KACZOROWSKI

ADDRESS

2525 FLEET ST.

25a. DATE REC'D. BY REGISTRAR

JUN 12 1979

25b. REGISTRAR'S SIGNATURE

Ricky Kaczkowski

00111 9

MR SOPHIE A WILKOWSKI

W 9 3 10

10 KINGS

CHURCH OF THE HOLY TRINITY

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CHURCH OF THE HOLY TRINITY

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

79 14767

REG. NO.

FOR  
 1 - STATE  
 REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           |                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>IMOGEN R. WILLET</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                           |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 6, 1979</b>                           |                                                                                                 | 2b. HOUR<br>M                                                                                                              |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                  | 4 RACE<br><b>WHITE</b>                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 16, 1894</b>                                                                                                 |                                                                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                             | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD                          |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>EDGEWOOD NURSING HOME</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>                                                                           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                |                                                                                                                                           | 13b. COUNTY                                                                                                                                                | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>703 CEDARCROFT RD.</b>                                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>T. IRVING ROTHEL</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE REICHARD</b>                                                                                    |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>220-30-0452</b>                                                                                                             |                                                                                      | 17 INFORMANT ADDRESS<br><b>DAVID MATTHEWS- SON SAME</b>                                         |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CAROTID ARTERY</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CAROTID BRADY SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) |                                                                                                                                           |                                                                                                                                                            |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                       |                                                                                                                                           |                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                            |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>S-8 19 79 7-30 19 69, to 6-6 19 79, that (I) (we) last<br>saw the deceased alive on 5-8 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                        |                                                                                                                                           |                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><i>Marcio Menendez</i> M.D.                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                           | DEGREE                                                                                                                                                     |                                                                                      | 22c. DATE SIGNED<br><b>6-6-79</b>                                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCIO MENENDEZ, M.D.</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | 22e. ADDRESS<br><b>5820 York Rd. Baltimore, Md.</b>                                                                                                        |                                                                                      |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                           | 23b. DATE<br><b>JUNE 6, 1979</b>                                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GUNPOWDER FRIENDS</b>                       |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 YORK RD. BALTO., MD.</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                                                        |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>                                            |                                                                                                                            |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14768

|                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |                                                                                |                                                                                                                                                             |                                                                                |                                                                                          |                                                                                      |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ARTIE AUSTIN WILLIAMS</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 22 79</b>                          |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>9:35 P.M.</b>                                                             |                                                                                      |                                                                                                                               |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>Black</b>                                                                                                                             |                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 14 15</b>                                                                                                        |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>                                             |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                     |                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |                                                                                      |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, Baltimore, Maryland 21218</b> |                                                                                |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steele Worker</b> |                                                                                      |                                                                                                                               |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     | 13b. COUNTY                                                                    |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                          |                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEVI WILLIAMS</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA AUSTIN</b>             |                                                                                                                                                             |                                                                                | 13e. STREET ADDRESS<br><b>207 Midland Avenue</b>                                         |                                                                                      |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 218-01-4122</b>                                                                   |                                                                                | 17. INFORMANT<br>ADDRESS<br><b>VAMC Records, Baltimore, Maryland 21218</b>                                                                                  |                                                                                |                                                                                          |                                                                                      |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1419</b><br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Squamous Cell Carcinoma of the Tongue</b>                   |  |                                                                                                                                                     |                                                                                |                                                                                                                                                             |                                                                                |                                                                                          |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                                                                                                                                                                                    |  |                                                                                                                                                     |                                                                                |                                                                                                                                                             |                                                                                |                                                                                          |                                                                                      |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |                                                                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  |                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                          |                                                                                      |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                    |  |                                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                          |                                                                                      |                                                                                                                               |  |
| 22a. I certify that (this hospital) attended the deceased from <b>June 6</b> , 19 <b>79</b> , to <b>June 22</b> , 19 <b>79</b> , that (we) last saw the deceased alive on <b>June 22</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. We did not view the body after death. |  |                                                                                                                                                     |                                                                                |                                                                                                                                                             |                                                                                |                                                                                          |                                                                                      |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Steven B. Schwartz</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     | DEGREE                                                                         |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br><b>6/23/79</b>                                                       |                                                                                      |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven B. Schwartz, MD</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     | 22e. ADDRESS<br><b>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b> |                                                                                                                                                             |                                                                                |                                                                                          |                                                                                      |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                     | 23b. DATE<br><b>6/28/79</b>                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PEEDER BARR.</b>                      |                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GREENAW S.C.</b>                    |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Margaret P. Hays</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>                            |                                                                                                                                                             |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                         |                                                                                      |                                                                                                                               |  |

9 21:0 22 79 9 22 9

EXHIBITS

WESTIN

WHITE

84

12

14

16

Black

White

Baltimore

12

U. S. A.

South Carolina

Steel's Book

West, Baltimore, Maryland, 1918

White

207 Midland Avenue

Baltimore

White

WESTIN

IDA

WHITE

WHITE

Steel's Book, Baltimore, Maryland, 1918

U. S. A.

WHITE

White

12

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16

18

20

22

24

Steel's Book, Baltimore, Maryland, 1918

U. S. A.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 6 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                   |                                                                                                                                       |                                                                                                                                                            |                                                                                                |                                                           |                    |
|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>CLEO HATTIE WILLIAMS                                        |                                                                                                                                       |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>06 12 79                                                 |                                                           | 2b HOUR<br>4 45 AM |
| 3 SEX<br>Female                                                                                   | 4 RACE<br>Caucasian                                                                                                                   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>03 11 1894                                                                                                            |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                 |                    |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA                                                    | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |                    |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                             | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Genl hosp |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b KIND OF BUSINESS OR INDUSTRY<br>Own Home              |                    |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD | 13b COUNTY<br>Anne Arundell                                                                                                           | 13c CITY OR TOWN<br>Baltimore                                                                                                                              | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>287 Hillside Terrace 21225          |                    |
| 14 FATHER'S NAME<br>FIRST JOHN<br>MIDDLE<br>LAST                                                  | 15 MOTHER'S MAIDEN NAME<br>FIRST FLORA<br>MIDDLE<br>LAST HARRIS                                                                       |                                                                                                                                                            |                                                                                                |                                                           |                    |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                         | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>819-74-1180                                                                 | 17 INFORMANT<br>Daughter: RUTH CLAUDE SAME AS ABOVE                                                                                                        |                                                                                                |                                                           |                    |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) Hypertensive and atherosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                               |                                                                       |                                                                                                                                            |                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                       | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                              |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                      | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                           |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from 06-12-1979 to 06-12-1979, that (I) (we) last saw the deceased alive on 06-12-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                       |                                                                                                                                            |                                                                                                                           |
| 22b SIGNATURE<br>R. Frey                                                                                                                                                                                                                                                                                      | DEGREE                                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br>06-12-79                                                                                               |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard AREM                                                                                                                                                                                                                                                          | 22e ADDRESS<br>South Baltimore General Hospital                       |                                                                                                                                            |                                                                                                                           |

|                                                                  |                     |                                                       |                                                                     |
|------------------------------------------------------------------|---------------------|-------------------------------------------------------|---------------------------------------------------------------------|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial               | 23b DATE<br>6/16/79 | 23c NAME OF CEMETERY OR CREMATORY<br>Glencoe Cemetery | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Big Stone Gap Virginia |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mc Cully Funeral Home of Brooklyn |                     | 25a DATE REC'D. BY REGISTRAR<br>JUN 12 1979           | 25b REGISTRAR'S SIGNATURE<br>F. J. [Signature]                      |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

POINT VI



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 1 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14770

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                            |                                                                                                                                                                                |                                                                                                                                                             |                                                                                                                             |                                      |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                            | 2a. DATE KNOWN<br>OF<br>DEATH<br>ESTIMATED                                                                                                                                     |                                                                                                                                                             | MONTH<br>DAY<br>YEAR                                                                                                        |                                      | 2b. HOUR<br>M                                                                       |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            | FIRST<br>DIANE                                                                                                                                                                 |                                                                                                                                                             | MIDDLE<br>WILLIAMS                                                                                                          |                                      | LAST<br>WILLIAMS                                                                    |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE                                                                                                    | 5. DATE OF BIRTH<br>MONTH<br>DAY<br>YEAR                                                                                                                                       | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)                                                                                                                        | IF UNDER 1 YR.<br>MONTHS<br>DAYS                                                                                            | IF UNDER 24 HRS.<br>HOURS<br>MIN     | 7c. DATE<br>PRONOUNCED<br>DEAD                                                      | 2d. HOUR<br>P M                                 |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                   | Black                                                                                                      | 4-14-1950                                                                                                                                                                      | 29 YRS.                                                                                                                                                     |                                                                                                                             |                                      | 6 21 19 79                                                                          | 8:20 P M                                        |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |                                                                                                                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                                     |                                                 |
| North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                           | U.S.A.                                                                                                     |                                                                                                                                                                                |                                                                                                                                                             |                                                                                                                             | Baltimore City, MD.                  |                                                                                     |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                                                                            |                                                                                                                             | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                                                                                     |                                                 |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                | Union Memorial Hospital                                                                                    |                                                                                                                                                                                | Machine Operator                                                                                                                                            |                                                                                                                             | Plastics                             |                                                                                     |                                                 |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               | 13b. COUNTY                                                                                                | 13c. CITY OR TOWN                                                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS                                                                                                         |                                      |                                                                                     |                                                 |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            | Baltimore                                                                                                                                                                      |                                                                                                                                                             | 3328 Burleigh Ave.                                                                                                          |                                      |                                                                                     |                                                 |
| 14. FATHER'S NAME<br>FIRST<br>RUAL                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                            | MIDDLE<br>WILLIAMS                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>VIOLA                                                                                                                  |                                                                                                                             | MIDDLE<br>BRYANT                     | LAST                                                                                |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                            | 16b. SOCIAL SECURITY NO.                                                                                                                                                       |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS                                                                                                    |                                      |                                                                                     |                                                 |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                            | 204-58-9043                                                                                                                                                                    |                                                                                                                                                             | EUGENE WILLIAMS 3328 Burleigh Ave.                                                                                          |                                      |                                                                                     |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): Multiple visceral and skeletal injuries<br>9571<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b):<br>(c):                                                                                                                                         |                                                                                                            |                                                                                                                                                                                |                                                                                                                                                             |                                                                                                                             |                                      |                                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                      |                                                                                                            |                                                                                                                                                                                |                                                                                                                                                             |                                                                                                                             |                                      |                                                                                     |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                              |                                                                                                                                                             |                                                                                                                             |                                      | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                |                                                                                                            | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR<br>7:18 P.M. 6 21 19 79 |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                               |                                      |                                                                                     |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                         |                                                                                                            | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>bridge                                                                                                       |                                                                                                                                                             | 21f. LOCATION<br>STREET<br>41st St. Bridge<br>CITY OR TOWN<br>and Jones Falls Expy., Baltimore City, Md.<br>COUNTY<br>STATE |                                      |                                                                                     |                                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                                                                            |                                                                                                                                                                                |                                                                                                                                                             |                                                                                                                             |                                      |                                                                                     |                                                 |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            | TITLE (SPECIFY)<br>Assistant                                                                                                                                                   |                                                                                                                                                             | MEDICAL EXAMINER                                                                                                            |                                      | DATE<br>SIGNED 6/22/79                                                              |                                                 |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                            | ADDRESS                                                                                                                                                                        |                                                                                                                                                             |                                                                                                                             |                                      |                                                                                     |                                                 |
| Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                            | 111 Penn Street                                                                                                                                                                |                                                                                                                                                             |                                                                                                                             |                                      |                                                                                     |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                             |                                                                                                                                                             | 23d. LOCATION<br>CITY OR TOWN                                                                                               |                                      | COUNTY STATE                                                                        |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6-27-1979                                                                                                  | Mt. Auburn Cem.                                                                                                                                                                |                                                                                                                                                             | Westport                                                                                                                    |                                      | Md.                                                                                 |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                            | ADDRESS                                                                                                                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                                                               |                                      | 25b. REGISTRAR'S SIGNATURE                                                          |                                                 |
| Erickson F.H.                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                            | - 1129 N. Caroline St.                                                                                                                                                         |                                                                                                                                                             | JUN 25 1979                                                                                                                 |                                      | Rickey H. Bandy                                                                     |                                                 |

01111 11

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 7 1

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                          |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                    |  | FIRST MIDDLE LAST<br>Emma L WILLIAMS                                                                                                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 27, 1979                                 |  | 2b. HOUR<br>7:15A M                                                                                                        |  |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br>Black                                                                                                                        |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>9 3 22                                                                                                     |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS                                             |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Va                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>942 S D                                                                                                |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                            |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |                                                                                                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>D. Smith         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Baltimore                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>438 N. and Court                                                                                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Brown                                                                                                                                                                                                                                                                                                                   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Percilla ?                                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                          |  | 16b. SOCIAL SECURITY NO.<br>222-10-4048                                              |  | 17 INFORMANT<br>Tyler 851 Greenway St.                                                                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u><br>585-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years                                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                  |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                               |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>June 18</u> 19 <u>79</u> , to <u>June 27</u> 19 <u>79</u> , that (X) (we) lost<br>saw the deceased alive on <u>June 27</u> 19 <u>79</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above (X) (we) (did) (not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Salvatore                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                 |  | DEGREE<br>M.D.                                                                       |  | 22c. DATE SIGNED<br>6-27-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph Salvatore, M.D.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  |                                                                                                                                                 |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                        |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>7.2.79                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>The Woodlawn                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore                              |  |                                                                                                                            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>L. Underhill                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                          |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. Brady                                                                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 7 7 2

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                       |                                                                                                                                                                  |                                                                           |                                                                                                       |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank E. Williams</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 26 79</b> |                                                                                                                                                                  |                                                                           | 2b. HOUR<br>M<br><b>6</b>                                                                             |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Black</b>                                                                                                               |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 2 22</b>                                                                                                              |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b><br>YRS MONTHS DAYS<br>IF UNDER 1 YEAR<br>IF UNDER 74 HRS |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                     |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2 Provident Hosp.</b> |                                                       |                                                                                                                                                                  |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                      |                                                                                                                            |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                          |                                                       | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                               |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Williams</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bernice Cager</b>                                                                 |                                                       |                                                                                                                                                                  |                                                                           |                                                                                                       |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 220-03-4371</b>                                                                                  |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Lucille E. Williams 2708 Elsinore Ave.</b>                                                                                        |                                                                           |                                                                                                       |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cardiomyopathy, ASHD.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b> |  |                                                                                                                                       |                                                       |                                                                                                                                                                  |                                                                           |                                                                                                       |                                                                                                                            |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |                                                       |                                                                                                                                                                  |                                                                           |                                                                                                       |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                                                       |                                                                                                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                   |                                                                           |                                                                                                       |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                |                                                                           |                                                                                                       |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1 1979</b> to <b>5-23 1979</b> that (I) (we) lost<br>saw the deceased alive on <b>June 4 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) see the body after death.                                                                                                                |  |                                                                                                                                       |                                                       |                                                                                                                                                                  |                                                                           |                                                                                                       |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>M. H. Chung</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                       | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                           | 22c. DATE SIGNED<br><b>6/28/79</b>                                                                    |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Myung H. Chung</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                       | 22e. ADDRESS<br><b>5670 The Alameda</b>                                                                                                                          |                                                                           |                                                                                                       |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>6/29/79</b>                                                                                                           |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                                                                                                   |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                               |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |                                                       | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                             |                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                                   |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Helen McNeely</b>                                                                                                               |                                                                           |                                                                                                       |                                                                                                                            |  |

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14773

|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HILMA K. WILLIAMS                                                                                                                                                                                                                                                                                                                                |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-4-79                                                                                                               |                                                                                       | 2b. HOUR<br>8:55A <sup>M</sup>                                                                  |                                   |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br>White                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 20 1890                                                                                                             |                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88<br>YRS. MONTHS DAYS HOURS MIN.                            |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Finland                                                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                   |
| 10. CITY OR TOWN OF DEATH<br>Balt. City                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mountbello Center |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cross & Blackwell |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>Baltimore                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Manual Kallio                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susanna                                                                                                    |                                                                                       | 16. ADDRESS<br>6902 Fait Ave.<br>Balto. MD 21224                                                |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                       |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>219-22-0223                                                                                                                     |                                                                                       | 17. INFORMANT<br>Albin R. Williams                                                              |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bilateral Pneumonitis<br>486-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5-6 days |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>Multiple Decubitus ulcers @ arteriosclerotic cardiovascular disease                                                                                                                                                                                                   |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from May 28, 1979, to June 4, 1979, that (I) (we) last saw the deceased alive on June 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                        |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |
| 22b. SIGNATURE<br>Corazon M. Cuevas, M.D.                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                | DEGREE                                                                                                                                                      |                                                                                       | 22c. DATE SIGNED<br>6-4-79                                                                      |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CORAZON M. CUEVAS, M.D.                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                | 22e. ADDRESS<br>2201 Argonne Dr., Balt., MD 21218                                                                                                           |                                                                                       |                                                                                                 |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                | 23b. DATE<br>6/7/79                                                                                                                                         |                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                         |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Baltimore, MD                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                | ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222                                                                                                              |                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>JUN 8 1979                                                     |                                   |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                |                                                                                                                                                             |                                                                                       |                                                                                                 |                                   |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14774

|                                                                                      |  |                                                                                                                                                     |                                                       |                                                                                                                                                             |                            |                                                                           |  |
|--------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES P. WILLIAMS</b>                      |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 22 79</b> |                                                                                                                                                             | 2b. HOUR<br><b>7:35 PM</b> |                                                                           |  |
| 3. SEX<br><b>Male</b>                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                             |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 16</b>                                                                                                       |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                     |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, Baltimore, Maryland 21218</b> |                                                       |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                    |  | 13a. STATE<br><b>Maryland</b>                                                                                                                       |                                                       | 13b. COUNTY                                                                                                                                                 |                            | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>603 Bright Street</b>                                                                                                     |                                                       | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Eley</b>                                                                                                |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ann Bradshaw</b> |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>                                                                              |                                                       | 17. INFORMANT<br><b>VAMC Medical Records, Baltimore, Maryland</b>                                                                                           |                            | ADDRESS                                                                   |  |

|                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                    |  |                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>                                   |  |                                                                                                                                                                                                                                                                                                                                                    |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                           |  |
| 410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Acute myocardial Infarction</b><br>(c) <b>Coronary Artery Disease</b> |  |                                                                                                                                                                                                                                                                                                                                                    |  |                                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Diabetes mellitus, Sepsis</b>               |  |                                                                                                                                                                                                                                                                                                                                                    |  |                                                                           |  |
| 19a. DATE OF OPERATION<br><b>6/22/79</b>                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gangrene Left Foot with amputation</b>                                                                                                                                                                                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                         |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                      |  | 22a. I certify that (this hospital) attended the deceased from <b>June 13</b> , 19 <b>79</b> to <b>June 22</b> , 19 <b>79</b> , that (we) last saw the deceased alive on <b>June 22</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death. |  |                                                                           |  |
| 22b. SIGNATURE<br><b>Steven B. Schwartz, MD</b>                                                                                                                                        |  | DEGREE                                                                                                                                                                                                                                                                                                                                             |  | 22c. DATE SIGNED<br><b>6/23/79</b>                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven B. Schwartz, MD</b>                                                                                                                 |  | 22e. ADDRESS<br><b>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>                                                                                                                                                                                                                                                                     |  |                                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                             |  | 23b. DATE<br><b>6-26-79</b>                                                                                                                                                                                                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                                                                               |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Isaiah L. Brown &amp; Son PA 1913 W. Balto. St.</b>                                                                                                                                                                                                                                                     |  |                                                                           |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert K. Brady</b>                                                                                                                                                                                                                                                                                               |  |                                                                           |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1a and 1b should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1000 Inland Haven Boulevard  
Baltimore, Maryland 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14775

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                 |  | FIRST MIDDLE LAST<br>Lloyd Williams                                                                                                                         |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>6 23 19 79                                         |  | 2b. HOUR<br>M<br>7:05 P. M.                                                         |                                              |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>black                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 2 22                                                                                                                |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>57 YRS.                                                   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>315 N. Gilmore Street |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |                                              |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY                                                                                                                         |  | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>315 N. Gilmore St.                                           |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vance Williams                                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanch Scarborough                                                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WWII                                               |  | 16b. SOCIAL SECURITY NO.<br>213-18-1484                                                         |  | 17. INFORMANT ADDRESS<br>Mattie Day 315 N. Gilmore St.                              |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                              |
| ACTUAL SIGNATURE<br>Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |  | TITLE (SPECIFY)<br>Assistant                                                                                                        |  | MEDICAL EXAMINER                                                                                                                                            |  | DATE SIGNED<br>6/24/79                                                                          |  |                                                                                     |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br>111 Penn Street, Baltimore, MD                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>6/29/79                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md.                                      |  |                                                                                     |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br>1101 E. North Ave.                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Lester K. Harvey                                                  |  |                                                                                     |                                              |

2017

2017-2018

2017-2018

2017-2018

2017-2018

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

79 14776

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                            |                                                                                         |                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Wilhelm F. Williams</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | 2a. DATE OF DEATH<br>June 6 <sup>Month</sup> Day 79 <sup>Year</sup>                                      |                                                                                                                                                             |                                                                            | 2b. HOUR<br>M                                                                           |                                                                                                 |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Black</b>                                                      |                                                                                                          | 5. DATE OF BIRTH<br><b>12-6-02</b>                                                                                                                          |                                                                            | 6. AGE (In years lost birthday)<br><b>77</b> YRS.                                       |                                                                                                 |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |                                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                            | 9. COUNTY OF DEATH<br><b>Baltimore, City</b> Md.                                        |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>524 Sheridan Ave.</b> |                                                                                                                                                             |                                                                            | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                              | 13b. COUNTY<br><b>Balto.</b>                                                                             |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Balto.</b>                                         |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Robert Williams</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Laura Williams</b>                                   |                                                                                                                                                             |                                                                            |                                                                                         |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>705-09-9588</b>                                                           |                                                                                                                                                             | 17. INFORMANT<br><b>Irene Williams</b> Address<br><b>524 Sheridan Ave.</b> |                                                                                         |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u><b>Acute myocardial Infarction</b></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u><b>2 minutes</b></u> |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                            |                                                                                         |                                                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u><b>Believe, renal, liver &amp; cerebral failure</b></u>                                                                                                                                                                                                                                                      |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                            |                                                                                         |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                                             |                                                                            |                                                                                         |                                                                                                 |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.) |                                                                                                          | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                                                                                             |                                                                            |                                                                                         |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u><b>June 6, 1978</b></u> , to <u><b>June 6, 1979</b></u> , that (I) (we) last saw the deceased alive on <u><b>June 5, 1979</b></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                    |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                            |                                                                                         |                                                                                                 |
| 22b. SIGNATURE<br><u><b>[Signature]</b></u><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                            | 22c. DATE SIGNED<br><u><b>June 11/79</b></u>                                            |                                                                                                 |
| 22d. PHYSICIAN'S NAME (Type)<br><u><b>DR E BERTRON</b></u>                                                                                                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br><u><b>302 E 33rd St Balto 2124</b></u>                       |                                                                                                          |                                                                                                                                                             |                                                                            |                                                                                         |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u><b>Burial</b></u>                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><u><b>6-12-79</b></u>                                           |                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><u><b>Arbutus Mem. Park</b></u>                                                                                       |                                                                            | 23d. LOCATION (City or Town) (County) (State)<br><u><b>Baltimore Md.</b></u>            |                                                                                                 |
| 24. FUNERAL DIRECTOR<br><u><b>Charles A. Rice</b></u> ADDRESS<br><u><b>1300 Eutaw Pl.</b></u>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                                                          | 25a. REC'D BY REGISTRAR<br>DATE<br><u><b>JUN 12 1979</b></u>                                                                                                |                                                                            | 25b. REGISTRAR'S SIGNATURE<br><u><b>[Signature]</b></u>                                 |                                                                                                 |

3  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2710

OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM

DATE

TO

FROM

SUBJECT

1. SUMMARY

2. DISCUSSION

3. ACTION

4. COMMENTS

5. RECOMMENDATION

6. CONCLUSION

7. REFERENCES

8. ATTACHMENTS

9. DISTRIBUTION

10. APPROVAL

11. SIGNATURE

12. DATE

13. INITIALS

14. REMARKS

15. OTHER

5

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9

14777

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             |                                                                                         |                                                                                      |                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William Robert Williams</i>                                                                                                                                                                                                                                                                         |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 9 79</i>                                    |                                                                                      | 2b. HOUR<br>M<br><i>12 M</i>                                   |
| 3. SEX<br><i>male</i>                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><i>black</i>                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 19 06</i>                                                                                                        |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HRS MIN.<br><i>73</i>            |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>ACC. MD</i>                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto city</i> MD.                        |                                                                |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University Hospital</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(12b. OF WORK FOR MOST OF WORKING LIFE)<br><i>Hard Laborer</i> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Brick</i>              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Md.</i> 13b. COUNTY <i>Balto</i> 13c. CITY OR TOWN <i>Balto</i>                                                                                                                                                                                           |                                                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS<br><i>202 N. Monroev St</i>                                         |                                                                                      |                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Rudolph W. Williams</i>                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ellen Jones</i>                                                                                         |                                                                                         |                                                                                      |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>no</i>                                                                                                                                                                                                                                                                                     |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><i>214-07-1683</i>                                                                                                              |                                                                                         | 12. INFORMANT<br>ADDRESS<br><i>Lorise Williams 202 N. Monroev St</i>                 |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>congestive heart failure</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>atherosclerotic coronary artery dis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>yr s</i>                                            |                                                                                                                                         |                                                                                                                                                             |                                                                                         |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1 wk</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>acute renal failure 2° to urate nephropathy</i>                                                                                                                                                                          |                                                                                                                                         |                                                                                                                                                             |                                                                                         |                                                                                      |                                                                |
| 19a. DATE OF OPERATION<br><i>June 9</i>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>                                                                                           |                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                       |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 1</i> 19 <i>79</i> , to <i>June 9</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>June 9</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                         |                                                                                                                                                             |                                                                                         |                                                                                      |                                                                |
| 22b. SIGNATURE<br><i>Col E Plitt</i>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | DEGREE<br><i>MD</i>                                                                                                                                         |                                                                                         | 22c. DATE SIGNED<br><i>6/9/79</i>                                                    |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Calvin E Plitt</i>                                                                                                                                                                                                                                                                                                     |                                                                                                                                         | 22e. ADDRESS<br><i>University Hospital</i>                                                                                                                  |                                                                                         |                                                                                      |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF)                                                                                                                                                                                                                                                                                                                            | 23b. DATE<br><i>6/13/79</i>                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MD National</i>                                                                                                    |                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Lanham MD</i>                       |                                                                |
| 24. FUNERAL DIRECTOR<br><i>Manhattan Funeral 638 N. Gilmor St</i>                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 11 1979</i>                                                                                                         |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McBrady</i>                                  |                                                                |

MEDICAL CERTIFICATION

2  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is not valid unless it is countersigned by the attending physician. The low requires that the death certificate be executed within 24 hours after death. Possession of this certificate is not valid unless it is countersigned by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES  
NATIONAL ARCHIVES  
COLLIERIE DISTRICT

11





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. REGISTRAR<br><b>RODNEY - CARTER</b>                                                                                                                                                                                                                                                                                                                       |  | 7 9 1 4 7 7 8                                                                                                                               |  | REG. NO.                                                                                                                                                       |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BABY BOY "A" WILLOUGHBY</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 16, 1979</b>                                                                                                    |  | 2b. HOUR<br><b>3:45 A.M.</b>                                                         |  |                                                                                                                            |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>Black</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6/16/79</b>                                                                                                           |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS. MONTHS DAYS<br><b>38</b>                   |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City.</b> MD.                   |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |                                                                                                                                                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>REGINALD JOSEPH CARTER</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARILYN LAVERNE WILLOUGHBY</b>                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>—</b>                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>MOTHER 1918 N. CHESTER ST.</b>                                                                                                  |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7651 IMMATURITY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>37 minutes</b>                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                           |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>16 JUNE 19 79</b> , to <b>16 JUNE 19 79</b> , that (we) last saw the deceased alive on <b>16 JUNE 19 79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did view the body after death.                                          |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>John F. Bober</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                      |  | 22c. DATE SIGNED<br><b>16 JUNE 79</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. BOBER, M.D.</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>6/21/79</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                           |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  | ADDRESS<br><b>Balto., Md.</b>                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>                                                                      |  |

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14779

|                                                                                                                      |                                                                                                                                                |                                                                                                                                                             |                                                                         |                                                                  |                                                                                                 |                                             |  |                                                 |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------|--|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BABY GIRL OF BRENDA WILSON</b>                                                |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 21, 1979</b>                |                                                                  |                                                                                                 | 2b. HOUR<br><b>238 A</b>                    |  |                                                 |
| 3. SEX<br><b>F</b>                                                                                                   | 4. RACE<br><b>W</b>                                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 3 79</b>                                                                                                         |                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>18</b> |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>18</b> |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>18</b>     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>    |                                                                                                 |                                             |  | MD                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO CITY</b>                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             |                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY           |  |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> |                                                                                                                                                |                                                                                                                                                             | 13b. COUNTY<br><b>BALTO</b>                                             | 13c. CITY OR TOWN<br><b>ESSEX</b>                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                             |  | 13e. STREET ADDRESS<br><b>121 TRAILWAYS RD.</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES R. WILSON</b>                                                     |                                                                                                                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BRENDA LEE RITZ</b> |                                                                  |                                                                                                 |                                             |  |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                    |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>—</b>                                                                                         |                                                                         | 17. INFORMANT<br>ADDRESS<br><b>PARENTS ABOVE</b>                 |                                                                                                 |                                             |  |                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) **IRREVERSIBLE ACIDOSIS AND ANOXIA**

**7689**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF  
(b) **PREMATURITY**

DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                    |                                                                                            |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b> | 21f. LOCATION<br>STREET<br><b>—</b>                                                        | CITY OR TOWN COUNTY STATE                                                                                                  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>3 JUNE</b> , 19 <b>79</b> , to <b>21 JUNE</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>21 JUNE</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |                                                                                    |                                                                                            |                                                                                                                            |
| 22b. SIGNATURE<br><b>Mary G. Murphy, MD</b>                                                                                                                                                                                                                                                                                                                              |                                                                                    | DEGREE<br><b>—</b>                                                                         | 22c. DATE SIGNED<br><b>21 JUNE 1979</b>                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY J. MURPHY</b>                                                                                                                                                                                                                                                                                                           |                                                                                    | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALTIMORE, MD.</b>                               |                                                                                                                            |

|                                                            |                             |                                                               |                                                                           |
|------------------------------------------------------------|-----------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>6/23/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSSVILLE BALTO. MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY F.H.</b>       |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>           |                                                                           |
| ADDRESS<br><b>300 MACE AVE.</b>                            |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Lester McBratney</b>         |                                                                           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled by funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove and retain page 4. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>(Name) Mamie L. WILSON</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 28 1979</b> |                                                                                                                                                             | 2b. HOUR<br><b>8:15P M</b> |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>Black</b>                                                                                                                       |                                                         | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 28 14</b>                                                                                                           |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |                                                                                                                            |  |                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                         |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                                                                                                       |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                  |                                                         | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2119 Druid Hill Avenue</b>                                                                       |  |                                                                                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Miller</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |                                                         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Susan Cobbs</b>                                                                                            |                            |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                                         | 16b. SOCIAL SECURITY NO.<br><b>144-20-7688</b>                                                                                                              |                            | 17. INFORMANT<br><b>Barbara Wilson</b>                                                          |  | ADDRESS<br><b>1505 Argyle Ave.</b>                                                                                         |  |                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>5609</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Hypotension (Cardiac Failure)</b><br>(c) <b>Intestinal Obstruction And Gangrene</b>                                  |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 Hours</b><br><b>48 Hours</b><br><b>3-4 Days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes And Emphysema</b>                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
| 19a. DATE OF OPERATION<br><b>June 25, 1979</b>                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intestinal Obstruction</b>                                                             |                                                         |                                                                                                                                                             |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                            |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                            |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
| 22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>June 24</b> , 19 <b>79</b> , to <b>June 28</b> , 19 <b>79</b> , that <del>xx</del> (we) lost saw the deceased alive on <b>June 28</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <del>xx</del> (we) (did) (not) view the body after death. |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            |                                                                                                 |  |                                                                                                                            |  |                                                                                                       |  |
| 22b. SIGNATURE<br><b>Mustafa Sidani</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            | DEGREE<br><b>Attending Physician</b>                                                            |  | 22c. DATE SIGNED<br><b>6-29-79</b>                                                                                         |  |                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mustafa Sidani, M.D.</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                            |  |                                                                                                                            |  |                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>7/2/79</b>                                                                                                                    |                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>                                                                                                  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |  |                                                                                                                            |  |                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |                                                         |                                                                                                                                                             |                            | ADDRESS<br><b>1101 E. North Ave.</b>                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. Brady</b>                                                 |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                |  |                                                                                                 |                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | N.                                                                                                                             |  | REG. NO.                                                                                        |                                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rebecca Wilson                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 31 79                                                     |                                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>Black                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 25 94                                                     |                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS                                                       |                                                              |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Harford Garden N. H. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                              |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                              |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  | 13b. COUNTY<br>Balto.                                                                           |                                                              |
| 13c. CITY OR TOWN<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eliza Syder Johnson                               |                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.                                                                                                       |  | 17. INFORMANT ADDRESS<br>Katherin Barnes 1706 W. Mosher St.                                     |                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Anemia</u> |  |                                                                                                                                |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Years</u> |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                  |                                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2</u> 19 <u>79</u> , to <u>May 2</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>May 24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                 |  |                                                                                                                                |  |                                                                                                 |                                                              |
| 22b. SIGNATURE<br><u>Joy M. Zimmerman MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  | 22c. DATE SIGNED<br>5/31/79                                                                     |                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Joy M. Zimmerman MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  | 22e. ADDRESS<br>3202 Harford Rd, Baltimore                                                      |                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>6/4/79                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                                          |                                                              |
| 23d. LOCATION CITY OR TOWN<br>Arbutus, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23e. COUNTY                                                                                                                    |  | 23f. STATE                                                                                      |                                                              |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | 25. DATE REC'D. BY REGISTRAR<br>JUN 5 1979                                                      |                                                              |
| 25. ADDRESS<br>1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  | 26. REGISTRAR'S SIGNATURE<br><u>Victory Holmes</u>                                              |                                                              |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14782

1- STATE REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                           |                                                                          |                                                                                                                                                             |                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THEODORE - WILSON</b>                                                                                                                                                                                                                                                                                                                                                                                        |                      | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6-24-79</b> |                                                                          | 2b. HOUR <b>7A</b>                                                                                                                                          |                                                                          |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE <b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JULY 30 1898</b>                                    | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>80 YRS.</b> | IF UNDER 1 YR.                                                                                                                                              | IF UNDER 24 HRS.                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                           |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                |                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt City</b>                                                                                                                                                                                                                                                                                                                                                                                               |                      | 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                |                                                                          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lobson</b>                                    |                                                                          |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lobson</b>                                                                                                                                                                                                                                                                                                                                                                         |                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                         |                                                                          | 13a. STREET ADDRESS <b>2018 mc callum. st</b>                                                                                                               |                                                                          |
| 13a. STATE <b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 13b. COUNTY <b>Bolt.</b>                                                                  |                                                                          | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                          |                                                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Loews R Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                        |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Isatie Roberts</b>                       |                                                                          |                                                                                                                                                             |                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                     |                      | 16b. SOCIAL SECURITY NO.                                                                  |                                                                          | 17. INFORMANT ADDRESS <b>George Cooper</b>                                                                                                                  |                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Vascular Disease</b><br>4409<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                       |                      |                                                                                           |                                                                          |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                  |                      |                                                                                           |                                                                          |                                                                                                                                                             |                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                         |                                                                          |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                           |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                               |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |                                                                                           |                                                                          |                                                                                                                                                             |                                                                          |
| ACTUAL SIGNATURE <b>Conrado Ferrero</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                      | TITLE (SPECIFY) <b>Deputy</b>                                                             |                                                                          | DATE SIGNED <b>6-24-79</b>                                                                                                                                  |                                                                          |
| EXAMINER'S NAME (TYPE OR PRINT) <b>CONRADO FERRERO</b>                                                                                                                                                                                                                                                                                                                                                                                              |                      | ADDRESS <b>5550 Balt Nth. Pike</b>                                                        |                                                                          |                                                                                                                                                             |                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 23b. DATE <b>6/27/79</b>                                                                  |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY <b>Deshloids</b>                                                                                                         |                                                                          |
| 24. FUNERAL DIRECTOR<br>NAME <b>George H. DeLund</b>                                                                                                                                                                                                                                                                                                                                                                                                |                      | ADDRESS <b>Baltimore</b>                                                                  |                                                                          | 25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1979</b>                                                                                                            |                                                                          |
| 25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                           |                                                                          |                                                                                                                                                             |                                                                          |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report obtained.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                         |  |                                                                                                        |  | REG. NO.                                                                                                                                                |  |                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | 7 9 1 4 7 8 3                                                                                                                                           |  |                                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                       |  |                                                                |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | MONTH DAY YEAR                                                                                                                                          |  |                                                                |  |
| VIETTA WILSON                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | JUNE 30 1971 7:30 PM                                                                                                                                    |  |                                                                |  |
| 3 SEX                                                                                                                                                                                                                                                                                        |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH                                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |
| F                                                                                                                                                                                                                                                                                            |  | Black                                                                                                  |  | MONTH DAY YEAR                                                                                                                                          |  | YRS MONTHS DAYS HOURS MIN.                                     |  |
| 11 18 98                                                                                                                                                                                                                                                                                     |  | 79 80                                                                                                  |  |                                                                                                                                                         |  |                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |
| Maryland                                                                                                                                                                                                                                                                                     |  | U.S.                                                                                                   |  |                                                                                                                                                         |  | Baltimore City MD.                                             |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore                                                                                                                                                                                                                                                                                    |  | Maryland University Hosp                                                                               |  | Housewife                                                                                                                                               |  | Home                                                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                            |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                       |  | 13e. STREET ADDRESS                                            |  |
| Maryland                                                                                                                                                                                                                                                                                     |  | Baltimore                                                                                              |  |                                                                                                                                                         |  | 3512 Wildcherry Road.                                          |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                             |  | 15 MOTHER'S MAIDEN NAME                                                                                |  | ADDRESS                                                                                                                                                 |  |                                                                |  |
| Richard                                                                                                                                                                                                                                                                                      |  | Marcia                                                                                                 |  | Road                                                                                                                                                    |  |                                                                |  |
| MIDDLE                                                                                                                                                                                                                                                                                       |  | MIDDLE                                                                                                 |  | LAST                                                                                                                                                    |  |                                                                |  |
| Hayward                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17 INFORMANT                                                                                                                                            |  |                                                                |  |
| NO                                                                                                                                                                                                                                                                                           |  | 217-52-8397                                                                                            |  | Mrs. Jean W. Purnell 3512 Wildcherry                                                                                                                    |  |                                                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):                                                                                                                                                                     |  | 4392                                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                            |  |                                                                |  |
| Gram $\ominus$ Sepsis                                                                                                                                                                                                                                                                        |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  | 78 days ago                                                                                                                                             |  |                                                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                |  | b. Chronic Urinary Tract Infection                                                                     |  | 320 days ago                                                                                                                                            |  |                                                                |  |
|                                                                                                                                                                                                                                                                                              |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  | 1.5y ago                                                                                                                                                |  |                                                                |  |
|                                                                                                                                                                                                                                                                                              |  | c. Cardiovascular Accident, atonic bladder                                                             |  |                                                                                                                                                         |  |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                |  |
| Breast Ca diagnosed 1 1/2 y ago, left mastectomy 1 1/2 y ago                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                |  |
|                                                                                                                                                                                                                                                                                              |  | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                           |  |                                                                |  |
|                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | CITY OR TOWN COUNTY STATE                                                                                                                               |  |                                                                |  |
| 22a. I certify that (1) this hospital attended the deceased from June 9, 1979, to June 30, 1979, that (2) I last saw the deceased alive on June 30, 1979, and that in my opinion death occurred on the date and hour and from the causes stated above; (3) I was given the body after death. |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                               |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | DATE SIGNED                                                    |  |
| Frank R. Claudy MD                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  | 6/30/79                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                        |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                         |  |                                                                |  |
| Frank R. Claudy                                                                                                                                                                                                                                                                              |  | 1820 Eutan Pl. Balto, Md. 21217                                                                        |  |                                                                                                                                                         |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION                                                  |  |
| Burial July 5, 79                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | Balto, Nat. Cem.                                                                                                                                        |  | Baltimore City Md.                                             |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  |                                                                |  |
| Herbert E. Nutter                                                                                                                                                                                                                                                                            |  | 3035 W. North Ave.                                                                                     |  | JUL 6 1979                                                                                                                                              |  |                                                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH


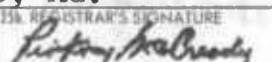
REG. NO.

9 1 4 7 8 4

|                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                                                |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                   |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                                                |
| FIRST MIDDLE LAST<br>WOODROW WILSON                                                                                                                                                                                                                                                                   |                                                                                                        | MONTH DAY YEAR<br>6-13-79                                                                                                                                |                                                                     | 11:25 PM                                                                       |                                                                |
| 3. SEX                                                                                                                                                                                                                                                                                                | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                                                                |                                                                |
| MALE                                                                                                                                                                                                                                                                                                  | N                                                                                                      | MONTH DAY YEAR<br>70-10-06                                                                                                                               | 72 YRS                                                              | MONTHS DAYS                                                                    | IF UNDER 24 HRS                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                |                                                                |
| VA                                                                                                                                                                                                                                                                                                    | USA                                                                                                    |                                                                                                                                                          | SOUTH BALTIMORE CITY MD                                             |                                                                                |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| BALTIMORE                                                                                                                                                                                                                                                                                             | SOUTH BALTIMORE - G. HOSP.                                                                             |                                                                                                                                                          | RETIRED                                                             |                                                                                |                                                                |
| 13a. STATE                                                                                                                                                                                                                                                                                            | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |                                                                |
| MARYLAND                                                                                                                                                                                                                                                                                              |                                                                                                        | BALTIMORE                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 504 ARCHER ST. 21230                                                           |                                                                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                     |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     |                                                                                |                                                                |
| FIRST MIDDLE LAST<br>WILLIE DEC WILSON                                                                                                                                                                                                                                                                |                                                                                                        | FIRST MIDDLE LAST<br>MATTIE WILLIE DEC WILSON                                                                                                            |                                                                     |                                                                                |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                     |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17. INFORMANT ADDRESS                                                          |                                                                |
| NO                                                                                                                                                                                                                                                                                                    |                                                                                                        | 217-07-6867                                                                                                                                              |                                                                     | Blannie Peele 504 Archer St.                                                   |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| 185- DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| (b) Male - 2° carcinoma.                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| (c) Pulm embolism?                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 5/3/79                                                                                                                                                                                                                                                                                                |                                                                                                        | Intestinal obstruction                                                                                                                                   |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                |
|                                                                                                                                                                                                                                                                                                       |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                     |                                                                                |                                                                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                |
|                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10/79 to 6/13/79, that (I) (we) last saw the deceased alive on 6/13/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                        |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                               |                                                                |
| Ali                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     | 6-13-79                                                                        |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                                |                                                                |
| ZAKIRAH K. ALI                                                                                                                                                                                                                                                                                        |                                                                                                        | S-B-C HOSPITAL                                                                                                                                           |                                                                     |                                                                                |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                             |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                        |                                                                |
| BURIAL                                                                                                                                                                                                                                                                                                |                                                                                                        | 6-19-79                                                                                                                                                  | MTT Auburn Cem                                                      | Ba/Ho                                                                          | MD                                                             |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                             |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                                                                |
| I. L. BROWN + SON                                                                                                                                                                                                                                                                                     |                                                                                                        | JUN 15 1979                                                                                                                                              |                                                                     | Rufus K. Kline                                                                 |                                                                |
| P.A. 1913 W. BALTIMORE ST                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                                                |



14785  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Claude</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | FIRST<br><b>Rodney</b>                                                                  |  | MIDDLE<br><b>Winder</b>                                                                                                                                     |  | LAST<br><b>Winder</b>                                                                                               |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> MONTH <b>6-6</b> DAY <b>19</b> YEAR <b>79</b> |  | 2b. HOUR<br><b>7:30</b>                                                                                                                  |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b>                                                                 |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>31</b> YEAR <b>51</b>                                                                                            |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>28</b> YRS.                                                                 |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                             |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                                       |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                       |  | 13a. STATE<br><b>Md.</b>                                                                                                                                    |  | 13b. COUNTY<br><b>Balto.</b>                                                                                        |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                          |  |
| 13e. STREET ADDRESS<br><b>2023 W. Lanvale St.</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 14. FATHER'S NAME<br>FIRST <b>Morion</b> MIDDLE <b>A.</b> LAST <b>Winder</b>            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Irene</b> MIDDLE <b>Dent</b> LAST <b>Dent</b>                                                                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                  |  | 16b. SOCIAL SECURITY NO.                                                                                                    |  | 17. INFORMANT<br><b>Irene Winder</b> ADDRESS<br><b>2023 W. Lanvale St.</b>                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple gun shot wound's (Unspecified)</b><br><b>9654</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                          |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |                                                                                                                                                             |  |                                                                                                                     |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                         |  |                                                                                                                                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR <b>7:16</b> P.M. MONTH <b>6</b> DAY <b>6</b> YEAR <b>79</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 PART 1 OR PART 2)<br><b>shot by assailant</b>                                                   |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>            |  | 21f. LOCATION<br>STREET <b>2000Blk Payner Ave,</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>MD</b> STATE <b>MD</b>                                              |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                |  | M.D. <b>Ann M. Dixon, M.D.</b>                                                          |  | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                                         |  | DATE SIGNED<br><b>6/7/79</b>                                                                                        |  |                                                                                                                             |  |                                                                                                                                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS <b>111 Penn Street, Balto. MD 21201</b>                                         |  |                                                                                                                                                             |  |                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>6/11/79</b>                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN <b>Arbutus, Md.</b> COUNTY <b>MD</b> STATE <b>MD</b>                                  |  |                                                                                                                             |  |                                                                                                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F. H.</b> ADDRESS <b>1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                                                                                                                             |  |                                                                                                                                          |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 N. EASTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76



C O P Y







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 7 8 6

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                             |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EMILIA WINICKZ</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 2 79</b>                   |                                                                                                                                                             |                                                                  | 2b. HOUR<br>MIN.<br><b>10.5</b> M                                                                                                                           |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                          |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 27 1895</b>                                                                                                      |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>84</b>                                                                                                        |                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                              |                                                                                                                            | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                    |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                           |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp</b> |                                                                        |                                                                                                                                                             |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                        |                                                                                      |                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                                                                      |                                                                        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                                      | 13e. STREET ADDRESS<br><b>202 Hillcrest Avenue</b>                           |                                                                                                                            |                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Cilinski</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Thecla Boranowski</b>                                                                                   |                                                                  |                                                                                                                                                             |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                         |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Julia Bernscheim 202 Hillcrest Avenue</b>                                                                                    |                                                                  |                                                                                                                                                             |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic failure</b><br><b>5728</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Jaundice</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>Stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                             |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                             |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  |                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                        |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                             |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 22b. SIGNATURE<br><b>Cheng - Hurd Liu M.D.</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      |                                                                              | 22c. DATE SIGNED<br><b>6-2-79</b>                                                                                          |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHENG - HURD LIU</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  | 22e. ADDRESS<br><b>South Baltimore General Hospital</b>                                                                                                     |                                                                                      |                                                                              |                                                                                                                            |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  | 23b. DATE<br><b>6/6/79</b>                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b> |                                                                                                                                                             |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore A.A. Maryland</b> |                                                                                                                            |                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  | ADDRESS<br><b>4001 Ritchie Highway</b>                                                                                                                      |                                                                                      |                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                         |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kelly</b>                                                                                                         |                                                                                      |                                                                              |                                                                                                                            |                                                |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

00111



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 7 8 7

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY May WINTERLING</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 23 79</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>2:50A M</b>                                                                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                                                                  |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 2, 1893</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS MONTHS DAYS HOURS MIN.                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b><br>MD.                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                              |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Deasel</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Weidner</b>                                                                                        |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-62-4258</b>                                                            |                                                       | 17. INFORMANT<br>ADDRESS<br><b>John Winterling 5118 Werrace Drive</b>                                                                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CHF CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                            |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 4</b> 19 <b>79</b> , to <b>JUNE 23</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>JUNE 23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (not) view the body after death. |  |                                                                                                                                          |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Becki Kuppiswamy MD</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |                                                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>6/23/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Becki Kuppiswamy</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |                                                       | 22e. ADDRESS<br><b>Church Hosp</b>                                                                                                                          |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>6-27-1979</b>                                                                                                            |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Avenue</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Reddy</b>                                                                        |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1973-74

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14788

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                            |                                                                                                                              |                                                                                                                                                         |                                                                             |                                                                                             |                                          |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH Wisniewski</b>                |                                                                                                                              |                                                                                                                                                         | 2a DATE OF DEATH MONTH DAY YEAR <b>JUNE 2 1979</b>                          |                                                                                             | 2b HOUR <b>M</b>                         |
| 3 SEX <b>male</b>                                                          | 4 RACE <b>WHITE</b>                                                                                                          | 5 DATE OF BIRTH MONTH DAY YEAR <b>2 18 1910</b>                                                                                                         |                                                                             | 6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS                                                |                                          |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>                     | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                               |                                          |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2320 FLEET ST.</b> |                                                                                                                                                         | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b> |                                                                                             | 12b KIND OF BUSINESS OR INDUSTRY         |
| 13a STATE <b>MARYLAND</b>                                                  |                                                                                                                              | 13b COUNTY <b>BALTIMORE</b>                                                                                                                             | 13c CITY OR TOWN <b>BALTIMORE</b>                                           | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS <b>2320 FLEET ST.</b> |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>                          |                                                                                                                              | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>                                                                                                |                                                                             |                                                                                             |                                          |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> |                                                                                                                              | 16b SOCIAL SECURITY NO <b>212 44 0614</b>                                                                                                               |                                                                             | 17 INFORMANT ADDRESS <b>JOSEPHINE TODD 623 S. CLINTON ST.</b>                               |                                          |

|                                                                                                                                                                                   |  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4292 Longest heart failure - pulmonary edema</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Valvular Heart disease</b>                                                                                                               |  | <b>5-10 years</b>                            |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b>                                                                                                                                |  | <b>10 years</b>                              |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                    |  |                                                                               |                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------|--|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                            |                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                         |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                            |                         | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                                                         |
| 22a I certify that (I) (this hospital) attended the deceased from <b>12-12-74</b> 19____, to <b>6/28/79</b> 19____, that (I) (we) lost saw the deceased alive on <b>4/28/79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                         |                                                                    |  |                                                                               |                                                                                                                         |
| 22b SIGNATURE <b>Hector L. Feliciano, M.D.</b>                                                                                                                                                                                                                                                                                                   |                         | DEGREE                                                             |  | 22c. DATE SIGNED <b>6/6/79</b>                                                |                                                                                                                         |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>HECTOR L. FELICIANO, M.D.</b>                                                                                                                                                                                                                                                                            |                         | 22e ADDRESS <b>7200 N. POINT RD 21219</b>                          |  |                                                                               |                                                                                                                         |
| 23a BURIAL CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                            | 23b. DATE <b>6/6/79</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>CLARKSON CEM</b>             |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>                   |                                                                                                                         |
| 24a FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>                                                                                                                                                                                                                                                                                          |                         | ADDRESS <b>2525 FLEET ST.</b>                                      |  | 25a DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>                                | 25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>                                                                      |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                               |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                               | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                           |                                         | 2b. HOUR                                                                                                                           |                                              |
| James M. Wisnouse                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                               | June 3, 1979                                                                                                                               |                                         | 9:16p <sub>M</sub>                                                                                                                 |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                            | 4. RACE                                                                                                | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |                                         | IF UNDER 1 YEAR MONTHS DAYS                                                                                                        |                                              |
| Male                                                                                                                                                                                                                                                                                              | White                                                                                                  | July 16, 1907                                                                                                                                            |                                                               | 71 YRS.                                                                                                                                    |                                         |                                                                                                                                    |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |                                         |                                                                                                                                    |                                              |
| Pennsylvania                                                                                                                                                                                                                                                                                      | U.S.A.                                                                                                 |                                                                                                                                                          |                                                               | Baltimore City MD.                                                                                                                         |                                         |                                                                                                                                    |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY       |                                                                                                                                    |                                              |
| Baltimore                                                                                                                                                                                                                                                                                         | The Johns Hopkins Hospital                                                                             |                                                                                                                                                          | Salesman                                                      |                                                                                                                                            | Amusements                              |                                                                                                                                    |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                        |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               | 13e. STREET ADDRESS                     |                                                                                                                                    |                                              |
| Pennsylvania                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          | Somerset                                                      |                                                                                                                                            | Parsons Hill                            |                                                                                                                                    |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                               |                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                          |                                         |                                                                                                                                    |                                              |
| Michael Wisnouse                                                                                                                                                                                                                                                                                  |                                                                                                        | Ann Cigan                                                                                                                                                |                                                               | No                                                                                                                                         |                                         |                                                                                                                                    |                                              |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                          |                                                                                                        | 17. INFORMANT                                                                                                                                            |                                                               | ADDRESS                                                                                                                                    |                                         |                                                                                                                                    |                                              |
| 191-28-4499                                                                                                                                                                                                                                                                                       |                                                                                                        | Anna B. Wisnouse                                                                                                                                         |                                                               | Somerset, Pa. 15501                                                                                                                        |                                         |                                                                                                                                    |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIAC ARREST                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE MYOCARDIAL INFARCT                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ISCHEMIC HEART DISEASE                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| Coronary Artery Disease - Left Ventricular Aneurysm                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                            |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 6/1/79                                                                                                                                                                                                                                                                                            |                                                                                                        | Coronary Artery Disease                                                                                                                                  |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                         |                                                                                                                                    |                                              |
|                                                                                                                                                                                                                                                                                                   |                                                                                                        | P.M. 19                                                                                                                                                  |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                          |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |                                         |                                                                                                                                    |                                              |
|                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/79 to 6/3/79, that (I) (we) lost saw the deceased alive on 6/3/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                    |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                         | 22c. DATE SIGNED                                                                                                                   |                                              |
| JAMES V. SITZMAN                                                                                                                                                                                                                                                                                  |                                                                                                        | MD                                                                                                                                                       |                                                               |                                                                                                                                            |                                         | 6/3/79                                                                                                                             |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                             |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| JAMES V. SITZMAN                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                         |                                                                                                                                    |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                         |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                            |                                                                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE |                                                                                                                                    |                                              |
| Burial                                                                                                                                                                                                                                                                                            |                                                                                                        | June 7, '79                                                                                                                                              | Somerset Co., Mem.                                            |                                                                                                                                            | Park Somerset, Pennsylvania             |                                                                                                                                    |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                         |                                                                                                        | ADDRESS                                                                                                                                                  |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                         | 25b. REGISTRAR'S SIGNATURE                                                                                                         |                                              |
| William E. Johnson                                                                                                                                                                                                                                                                                |                                                                                                        | 8521 Loch Raven Blvd                                                                                                                                     |                                                               | JUN 7 1979                                                                                                                                 |                                         | Ritzy Hebrudy                                                                                                                      |                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by article.

BP



5851



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14790

FOR  
1- STATE  
REGISTRAR

|                                                                           |  |                                                                                                                                              |  |                                                                                                                                                            |  |                                                                                                |  |
|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILDRED</b><br><i>MILDRED</i>    |  | FIRST <b>MILDRED</b> MIDDLE<br><b>WISWELL</b> LAST<br><i>WISWELL</i>                                                                         |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>6 29 79</b>                                                                                                          |  | 2b HOUR<br><b>12:50pm</b>                                                                      |  |
| 3 SEX<br><b>Female</b>                                                    |  | 4 RACE<br><b>White</b>                                                                                                                       |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>4 14 01</b>                                                                                                           |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>               |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                              |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University of Md Hospital</i> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dept of Airforce</b>                                                                 |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                                             |  |
| 13a STATE<br><b>Md</b>                                                    |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                               |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST <b>Merton</b> MIDDLE <b>V.</b> LAST <b>Hill</b> |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Edith</b> MIDDLE <b>Hurd</b> LAST <b>Hurd</b>                                                            |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                           |  |                                                                                                |  |
| 16b SOCIAL SECURITY NO.<br><b>218 32-0656</b>                             |  | 17 INFORMANT <b>Robert N. Phillips</b><br><b>Rt2 Box 2573A Hamilton, Montana 59840</b>                                                       |  |                                                                                                                                                            |  |                                                                                                |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Coronary Artery Failure*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*Rheumatic Heart Disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Fractured Hip*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                 |  |                                                                                                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|
| 19a DATE OF OPERATION<br><b>-</b>                                                                                                                                                                                                                                                                                                                |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                                            |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                        |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                               |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6 29 1979</b><br>P.M.                             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><i>Fall at Institution</i>                     |  |                                                                                                                              |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                      |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>Rodell's Conescent Bme</i> |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                |  |                                                                                                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>6/29/79</i> , 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <i>6/29/79 - 1230</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                 |  |                                                                                                                              |  |
| 22b SIGNATURE<br><i>J. DESILVA</i>                                                                                                                                                                                                                                                                                                               |  | DEGREE<br><i>MD</i>                                                                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><i>6/29/79</i>                                                                                            |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. DESILVA</b>                                                                                                                                                                                                                                                                                        |  | 22e ADDRESS<br><i>University of Md Hospital</i>                                                        |  |                                                                                                                                 |  |                                                                                                                              |  |

|                                                                                                                             |  |                           |  |                                                                |  |                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------|--|---------------------------|--|----------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                |  | 23b DATE<br><b>7/3/79</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Witzke Funeral Home of Catonsville</b><br><b>1630 Edmondson Avenue Catonsville, Maryland</b> |  |                           |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>              |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 9 1

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------|------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                         |              | FIRST<br>BARBARA                                                                                          | MIDDLE<br>Faye | LAST<br>WOLFE                                                                                                                                               | 2a. DATE OF DEATH                                                                   |                                                                     | MONTH<br>6                          | DAY<br>25                                                      | YEAR<br>79 | 2b. HOUR<br>5:34 P.M.                           |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br>W | 5. DATE OF BIRTH                                                                                          |                | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                             |                                                                                     | IF UNDER 1 YEAR                                                     |                                     | IF UNDER 74 HRS                                                |            |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                             |              | MONTH<br>6                                                                                                |                | DAY<br>22                                                                                                                                                   |                                                                                     | YEAR<br>50                                                          |                                     | 29 YRS                                                         |            |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                   |              | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                     |                                                                |            |                                                 |
| Maryland                                                                                                                                                                                                                                                                                                                                                                    |              | USA                                                                                                       |                |                                                                                                                                                             |                                                                                     | Baltimore City MD                                                   |                                     |                                                                |            |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                   |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                                                                                                                                                             |                                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                     | 12b. KIND OF BUSINESS OR INDUSTRY                              |            |                                                 |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                   |              | Baltimore City Hospitals                                                                                  |                |                                                                                                                                                             |                                                                                     | Unemployed -ill                                                     |                                     |                                                                |            |                                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                     |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                  |              | 13b. COUNTY                                                                                               |                | 13c. CITY OR TOWN                                                                                                                                           |                                                                                     | 13d. INSIDE CITY LIMITS?                                            |                                     | 13e. STREET ADDRESS                                            |            |                                                 |
| Md                                                                                                                                                                                                                                                                                                                                                                          |              | -                                                                                                         |                | Baltimore                                                                                                                                                   |                                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     | 416 Fawcett Street                                             |            |                                                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                           |                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                                            |                                                                     |                                     |                                                                |            |                                                 |
| FIRST<br>Charles D. Wolfe                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                           |                |                                                                                                                                                             | FIRST<br>Pearl Buckley                                                              |                                                                     |                                     |                                                                |            |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                        |              |                                                                                                           |                |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                                            |                                                                     | 17. INFORMANT                       |                                                                | ADDRESS    |                                                 |
| no                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                           |                |                                                                                                                                                             | 214 58 6109                                                                         |                                                                     | Charles Wolfe                       |                                                                | Same       |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                   |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| 7100 DUE TO, OR AS A CONSEQUENCE OF <u>CHRONIC KIDNEY FAILURE</u>                                                                                                                                                                                                                                                                                                           |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                              |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF <u>SYSTEMIC LUPUS ERYTHEMATOSIS</u>                                                                                                                                                                                                                                                                                                          |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                          |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| COMA/unknown etiology - seizures - status epilepticus                                                                                                                                                                                                                                                                                                                       |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                |                                                                                                                                                             |                                                                                     | 20a. AUTOPSY?                                                       |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |            |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |            |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                   |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                | 21f. LOCATION<br>STREET                                                                                                                                     |                                                                                     | CITY OR TOWN                                                        |                                     | COUNTY                                                         |            | STATE                                           |
|                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/19/79</u> , 19 <u>79</u> , to <u>6/25/79</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/25/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |              |                                                                                                           |                |                                                                                                                                                             |                                                                                     |                                                                     |                                     |                                                                |            |                                                 |
| 22b. SIGNATURE<br><u>Dee Dee Hamm</u>                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                           |                |                                                                                                                                                             | DEGREE                                                                              |                                                                     |                                     | 22c. DATE SIGNED<br><u>5/25/79</u>                             |            |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>HILLER HAMMERMAN</u>                                                                                                                                                                                                                                                                                                            |              |                                                                                                           |                |                                                                                                                                                             | 22e. ADDRESS<br><u>Baltimore City Hospitals 4440 Eastern Ave<br/>Balt. MD 21214</u> |                                                                     |                                     |                                                                |            |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                |              | 23b. DATE                                                                                                 |                | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                     | 23d. LOCATION<br>CITY OR TOWN                                       |                                     |                                                                |            |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                                                                      |              | 2/29/79                                                                                                   |                | Woodlawn Cemetery                                                                                                                                           |                                                                                     | Woodlawn Baltimore MD                                               |                                     |                                                                |            |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                           |                |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                       |                                                                     | 25b. REGISTRAR'S SIGNATURE          |                                                                |            |                                                 |
| Burgee Funeral Home                                                                                                                                                                                                                                                                                                                                                         |              |                                                                                                           |                |                                                                                                                                                             | 3631 Falls Road 21211                                                               |                                                                     | JUN 28 1979 <u>Jeffrey McCreedy</u> |                                                                |            |                                                 |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | REG. NO. 9 1 4 7 9 2                                                                                                                       |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William Joseph WOLYNSKI</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 28, 1979</b>                                        |  | 2b. HOUR<br><b>8:30A M</b>                                                                                                 |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>White</b>                                                                                                                     |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>February 10, 1915</b>                                                                                                 |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                                |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Crain Operator</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ship Building</b>                                                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1209 Church Street</b>                                                                           |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Felix Wolynski</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Antionette Patchiviz</b>                                                                                   |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO<br><b>186-14-1006</b>                                                                                              |  | 17 INFORMANT<br><b>Mrs Elsie Wolynski</b>                                                                                                                  |  | ADDRESS<br><b>Same Address</b>                                                                  |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 19</b> , 19 <b>79</b> , to <b>June 28</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 28</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Charles Graham, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                             |  | 22c. DATE SIGNED<br><b>6-28-79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Graham, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |  |                                                                                                                                                            |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>7/2/79</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. pk</b>                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Co. Md</b>                       |  |                                                                                                                            |  |
| 24 FUNERAL DIRECTOR NAME<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                            |  | ADDRESS<br><b>4001 Ritchie Hwy, Balto</b>                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  |                                                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                |  |                                                                                                                            |  |

SEAL 67

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7-9

14793

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |                                                          |                                                                                                                                                            |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES IRVIN WOOD</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 28, 1979</b> |                                                                                                                                                            | 2b. HOUR<br><b>4:40 PM</b>                                                                                                                           |                                                                                                 |                                                                                                                            |                                                                 |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>White</b>                                                                                                           |                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 24 1898</b>                                                                                                 |                                                                                                                                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                                 |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                    |                                                          | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |                                                                                                                            |                                                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL NAME AND STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                          |                                                                                                                                                            |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Purch. Agent</b>         |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |                                                          |                                                                                                                                                            |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                     |                                                          | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                         |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>1103 Ramblewood Rd.</b>               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel I Wood</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |                                                          |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Houchens</b>                                                                               |                                                                                                 |                                                                                                                            |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 1</b>                                                           |                                                          | 17 INFORMANT<br><b>Ruby B. Wood</b>                                                                                                                        |                                                                                                                                                      |                                                                                                 | ADDRESS<br><b>Same</b>                                                                                                     |                                                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>bacterial meningitis (Streptococcus)</b><br><b>3202</b> DUE TO, OR AS A CONSEQUENCE OF <b>pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs.</b> |  |                                                                                                                                  |                                                          |                                                                                                                                                            |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |                                                          |                                                                                                                                                            |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
| 19a. DATE OF OPERATION<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                                                                     |                                                          |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                |                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/25</b> , 19 <b>79</b> , to <b>6/28</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                              |  |                                                                                                                                  |                                                          |                                                                                                                                                            |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                 |  |
| 22b. SIGNATURE<br><b>Paul Gertler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |                                                          |                                                                                                                                                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6/28/79</b>                                                                                         |                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL GERTLER M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |                                                          |                                                                                                                                                            | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                       |                                                                                                 |                                                                                                                            |                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>7-2-79</b>                                                                                                       |                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l.</b>                                                                                              |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Va.</b>                              |                                                                                                                            |                                                                 |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>H.W. Jenkins &amp; Sons Co. Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                         |                                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey H. Brady</b>                                           |                                                                                                                            |                                                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CP 1 A 1 67



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 7 9 4

|                                                                                   |  |                                                                                                                                                 |                                                                                    |                                                                                                                                                         |  |                                                                                     |  |                                            |                                                                                     |  |
|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|--------------------------------------------|-------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLARENCE WOODALL</b>                     |  |                                                                                                                                                 | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 6 79</b>                                |                                                                                                                                                         |  | 2b HOUR<br><b>3:20 PM</b>                                                           |  |                                            |                                                                                     |  |
| 3 SEX<br><b>MALE</b>                                                              |  | 4 RACE<br><b>BLACK</b>                                                                                                                          |                                                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 28 25</b>                                                                                                     |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                    |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>54</b> |                                                                                     |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MILLEDGEVILLE, GA.</b>             |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                    |                                                                                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |  |                                            |                                                                                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER BALTO. MD.</b> |                                                                                    |                                                                                                                                                         |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Insurance</b> |  | 12b KIND OF BUSINESS OR INDUSTRY           |                                                                                     |  |
| 13a STATE<br><b>MARYLAND</b>                                                      |  |                                                                                                                                                 | 13b COUNTY                                                                         |                                                                                                                                                         |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                |  |                                            | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>POKES WOODALL</b>                     |  |                                                                                                                                                 | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ADA JEN</b>                     |                                                                                                                                                         |  | 16 STREET ADDRESS<br><b>440 N. GATE STREET 21202</b>                                |  |                                            |                                                                                     |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |  |                                                                                                                                                 | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 257-24-1180</b> |                                                                                                                                                         |  | 17 INFORMANT ADDRESS<br><b>ARTHUR TRIMBLE 2217 RUSKIN AVE</b>                       |  |                                            |                                                                                     |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Pneumonia (sepsis)**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

|                                                                                                                                                                                                                                                                                                                                                     |  |                                                                       |  |                                                                                                                                                      |  |                                                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                        |  |                                                                                                                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                       |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                     |  |                                                                                                                           |  |
| 22a I certify that <b>X</b> (this hospital) attended the deceased from <b>JUNE 5, 19 79</b> , to <b>JUNE 6, 19 79</b> , that <b>X</b> (we) lost saw the deceased above <b>JUNE 6, 19 79</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) (did) not view the body after death. |  |                                                                       |  |                                                                                                                                                      |  |                                                                                                                           |  |
| 22b SIGNATURE<br><b>Scott Glazer</b>                                                                                                                                                                                                                                                                                                                |  |                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>6/7/79</b>                                                                                          |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Scott Glazer MD</b>                                                                                                                                                                                                                                                                                      |  |                                                                       |  | 22e ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218</b>                                                                                     |  |                                                                                                                           |  |

|                                                           |  |                            |  |                                                      |  |                                                                               |  |
|-----------------------------------------------------------|--|----------------------------|--|------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b> |  | 23b DATE<br><b>6/13/79</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>McCauley</b> |  | 23d LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Baltimore MD 21225</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Manfred A. Lopez</b>    |  |                            |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Patricia Brady</b>                            |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

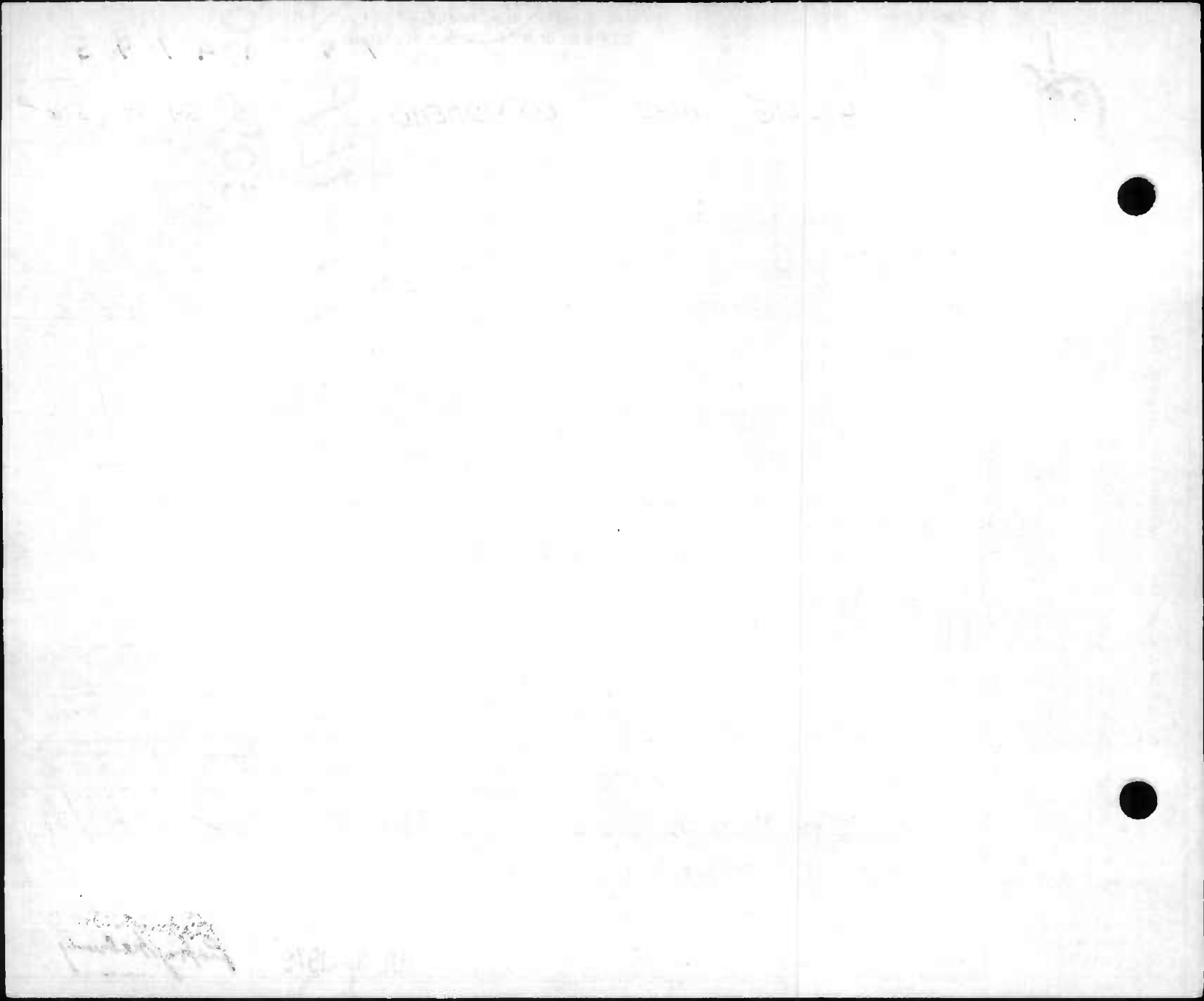
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released on approval by Dr. Thomas Smith

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                           |  | 2b. HOUR                                     |  |
| LILLIE                                                                                                                                                                                                                                                                                                                                                                   |  | MAE                                                                                                    |  | WOODHEAD                                                                                                                                                |  |                                                                                                 |  | 6 29 79                                                                                                                                    |  | 5:00 PM                                      |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| Female                                                                                                                                                                                                                                                                                                                                                                   |  | White                                                                                                  |  | 12 26 1892                                                                                                                                              |  | 86 YRS                                                                                          |  |                                                                                                                                            |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                             |  |                                                                                                                                            |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                 |  | U.S.A.                                                                                                 |  |                                                                                                                                                         |  | Baltimore City MD.                                                                              |  |                                                                                                                                            |  |                                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                         |  |                                                                                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                |  | Baltimore City Hospitals                                                                               |  |                                                                                                                                                         |  |                                                                                                 |  | Housewife                                                                                                                                  |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS                                                                                                                        |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                 |  | Baltimore                                                                                              |  | Edgemere                                                                                                                                                |  |                                                                                                 |  | 7603 Old Road Bayfront                                                                                                                     |  |                                              |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                    |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                           |  |                                                                                                                                                         |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
| Mordecai                                                                                                                                                                                                                                                                                                                                                                 |  | Peters                                                                                                 |  | Dora                                                                                                                                                    |  | Smith                                                                                           |  |                                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17 INFORMANT                                                                                                                                            |  | ADDRESS                                                                                         |  |                                                                                                                                            |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                       |  | 213-09-3526                                                                                            |  | Dorothy M. Weston - Balto.                                                                                                                              |  | MD 21219                                                                                        |  |                                                                                                                                            |  |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>advanced age, generalized debilitation</u> |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                 |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>9 hip fracture 6/12.</u>                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                       |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>79</u> , to <u>6/29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.             |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><u>Angela C Healy MD</u>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | DEGREE                                                                                                                                                  |  |                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/29/79</u>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ANGELA C HEALY MD</u>                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 22e. ADDRESS<br><u>Balto City Hosp 4940 Eastern Ave 21224</u>                                                                                           |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                                            |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                   |  | 7/3/79                                                                                                 |  | Oak Lawn Cemetery                                                                                                                                       |  | Baltimore, Baltimore, MD                                                                        |  |                                                                                                                                            |  |                                              |  |
| 24 FUNERAL DIRECTOR NAME<br><u>Duda-Ruck, Inc</u>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                |  |                                                                                                                                            |  |                                              |  |
| 7922 Wise Avenue, Dundalk, MD 21222                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | JUL 3 1979                                                                                                                                              |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14796  
REG. NO.

|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                       |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                             |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                            |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | HOUR                                                                           |                                              |
| HENRY WOODS                                                                                                                                                                                                                                                                                                  |                                                                                                        | JUNE 6 / 22 / 79                                                                                                                                         |                                                                     | 12.30 P.M.                                                                     |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                       | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR                                                             |                                              |
| MALE                                                                                                                                                                                                                                                                                                         | NEGRO                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 65 YRS.                                                             | IF UNDER 24 HRS                                                                |                                              |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                    | 7c. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                |                                              |
| VIRGINIA                                                                                                                                                                                                                                                                                                     | U.S.A.                                                                                                 |                                                                                                                                                          | BALTIMORE CITY MD.                                                  |                                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE                                                                                                                                                                                                                                                                                                    | LUTHERAN HOSP 730 ASHBURTON ST                                                                         |                                                                                                                                                          | LABORER                                                             |                                                                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                   | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 14. INSIDE CITY LIMITS?                                             | 15. STREET ADDRESS                                                             |                                              |
| md.                                                                                                                                                                                                                                                                                                          |                                                                                                        | CITY                                                                                                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3031 Harlem Ave                                                                |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     |                                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                            |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                                     |                                                                                |                                              |
| JIMMIE WOODS                                                                                                                                                                                                                                                                                                 |                                                                                                        | BERTIE TRAVIS                                                                                                                                            |                                                                     |                                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                            |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17. INFORMANT ADDRESS                                                          |                                              |
| NO                                                                                                                                                                                                                                                                                                           |                                                                                                        | 217-07-9800                                                                                                                                              |                                                                     | FRED WOODS / 3031 HARLEM AVE. 21216                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                | Days                                         |
| 436- DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| Carcinoma of right lung. Aspiration pneumonia left lung                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                  |                                              |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                              |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                                     |                                                                                |                                              |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                     |                                                                                |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                         |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION                                                                  |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     | STREET CITY OR TOWN COUNTY STATE                                               |                                              |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/22 1979, to 6/22 1979, that (I) (we) last saw the deceased alive on 6/22 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                               |                                              |
| Sujeta Sapsiri                                                                                                                                                                                                                                                                                               |                                                                                                        | M.D.                                                                                                                                                     |                                                                     | 6-22-79                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                        |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                                |                                              |
| SUJETA SAPSIRI                                                                                                                                                                                                                                                                                               |                                                                                                        | Lutheran Hospital of Maryland                                                                                                                            |                                                                     |                                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                    |                                                                                                        | 23b. DATE                                                                                                                                                |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                       |                                                                                                        | 06/26/79                                                                                                                                                 |                                                                     | WESTVIEW MEM. A.                                                               |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                    |                                                                                                        | 24b. ADDRESS                                                                                                                                             |                                                                     | 25a. DATE REC'D. BY REGISTRAR                                                  |                                              |
| MARSHALL W. JONES JR                                                                                                                                                                                                                                                                                         |                                                                                                        | 4101 EDMONDSON AVENUE                                                                                                                                    |                                                                     | JUN 27 1979                                                                    |                                              |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                                              |
|                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     | R. J. H. H. H.                                                                 |                                              |

0 9 1 1 1 1

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14797

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | FIRST MIDDLE LAST<br>MARY (Mae) C. WOODS                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 19, 1979                                                                                                        |  | 2b. HOUR<br>7:35A                                                                                                          |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 3, 1908                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70                                                                                      |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hospital Corp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker                                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>----                                                                                                                     |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Deal                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Cain                                                                              |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                  |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br>214-62-8628                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 17. INFORMANT<br>Baltimore, Md. 21224<br>Mr. Edward J. Carey-2930 E. Baltimore                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>436- ACUTE CEREBROVASCULAR ACCIDENT - SEPTIC SHOCK<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE, CHRONIC<br>DUE TO, OR AS A CONSEQUENCE OF, OBSTRUCTIVE PULMONARY DISEASE, RESPIRATORY<br>FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (1) this hospital attended the deceased from JUNE 9, 1979, to JUNE 19, 1979, that (1) we last saw the deceased alive on JUNE 19, 1979 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If (a) and (b) are not, view the body after death.)                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>John A. Moran</i>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                                                  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>6-19-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALKER IMPAGLIATELLI, M.D.                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>6/23/79                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery - Baltimore, Maryland                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John A. Moran, Inc.                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br>3000 E. Baltimore St.<br>Baltimore, Md. 21224                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 21 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert J. McElroy</i>                                                                     |  |

BP



1 4 1 9 1

(See) C.

Female

White

July 3, 1908

70

Baltimore, Md.

U.S.A.

x

Baltimore City

Baltimore

Church Home Hospital Corp.

Housewife

Homeowner

Md.

Baltimore

x

2823 Resland Avenue

?

Deal

Ello

Cain

no

214-52-882

at. Edward J. Carey-2230 E. Baltimore

Baltimore, Md. 21214

214-52-882

214-52-882

Bureau of Census - Baltimore, Maryland

1908-1909  
1909-1910  
1910-1911

1910-1911



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 7 9 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                          |                                                                                                                              |                                                                                                                                                             |                                                      |                                                                                                 |                                         |                                                                  |  |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CARROLL E. WRIGHT |                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 25, 1979 |                                                                                                 |                                         | 2b. HOUR<br>8:09A <sup>M</sup>                                   |  |
| 3 SEX<br>MALE                                            | 4 RACE<br>WHITE                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JANUARY 25, 1911                                                                                                      |                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                                      |                                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                         |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL |                                                                                                                                                             |                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED AUTO WORKER         |                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>GENERAL MOTOR               |  |
| 13a. STATE<br>Md.                                        |                                                                                                                              | 13b. COUNTY<br>-                                                                                                                                            | 13c. CITY OR TOWN<br>BALTO.                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1119 BUNBURY WAY |                                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM WRIGHT |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EMMA TILGHMAN                                                                                              |                                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO                         |                                         |                                                                  |  |
| 16b. SOCIAL SECURITY NO.<br>216-01-7534                  |                                                                                                                              | 17. INFORMANT<br>MRS. HELEN F. WRIGHT                                                                                                                       |                                                      | ADDRESS<br>(SAME)                                                                               |                                         |                                                                  |  |

|                                                                                                                                                                                                                                                                                 |  |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 0270<br>DUE TO OR AS A CONSEQUENCE OF BLEEDING PEPTIC ULCER<br>(b)<br>DUE TO OR AS A CONSEQUENCE OF LISTERIA SEPTICEMIA, HEMOCHROMATOSIS<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                              |  |                                                 |

|                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                      |                                                                                      |                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (1) this hospital attended the deceased from JUNE 1, 1979, to JUNE 25, 1979, that (1) we last saw the deceased alive on JUNE 25, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |                                                                                                                                                      |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br>A. C. Chouvalit, M.D.                                                                                                                                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>6-25-79                                                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. C. CHOUVALIT, M.D.                                                                                                                                                                                                                                                      | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD                                                                        |                                                                                      |                                                                                                                               |

|                                                        |                            |                                                               |                                                          |
|--------------------------------------------------------|----------------------------|---------------------------------------------------------------|----------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>6-28-1979     | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLYHILLS MEMORIAL PK. | 23d. LOCATION<br>CITY OR TOWN COUNTY/ STATE<br>BALTO. MD |
| 24. FUNERAL DIRECTOR<br>J. Maltzbecker                 | ADDRESS<br>5444 BELAIR RD. | 25a. DATE REC'D. BY REGISTRAR<br>JUN 29 1979                  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Postmortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14799

|                                                            |  |                                        |                                                      |                                                                                                                                                             |  |                                                            |  |                                                                 |  |
|------------------------------------------------------------|--|----------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HELEN Lucile WRIGHT |  |                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 12, 1979 |                                                                                                                                                             |  | 2b. HOUR<br>7:30A M                                        |  |                                                                 |  |
| 3. SEX<br>Female                                           |  | 4. RACE<br>White                       |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 5, 1932                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pomfret, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |  |                                                                 |  |

|                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                               |  |  |                                                                                                 |  |  |
|-----------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                               |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                       |  |  |
| 13a. STATE<br>Md.                                                     |  |  | 13b. COUNTY<br>Charles                                                                                                                                                                                                                                                                                                                                                                |  |  | 13c. CITY OR TOWN<br>Bryans Road                                              |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Guy Charles Hamilton        |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Bryan                                                                                                                                                                                                                                                                                                                       |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No    |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>578-42-3709                           |  |  |
| 17. INFORMANT<br>ADDRESS<br>Wm. E. Wright P.O. Box 146 Bryans Rd. Md. |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular accident<br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Diabetes mellitus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Atherosclerosis |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hours<br>15 years          |  |  |                                                                                                 |  |  |

|                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br>Pancreatectomy                                                                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>6/11/79                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Chronic Pancreatitis                                                   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                 |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                        |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/23/79 to 6/12/79, that (I) (we) last saw the deceased alive on 6/12/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>R. J. Postier MD                                                                                         |  |
| 22c. DATE SIGNED<br>6/12/79                                                                                                                                                                                                                                                                           |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Postier                                                                           |  |
| 22e. ADDRESS<br>Johns Hopkins Hosp                                                                                                                                                                                                                                                                    |  | 22f. DEGREE<br>DEGREE                                                                                                      |  |

|                                                     |  |                           |  |                                                                |  |                                                                   |  |
|-----------------------------------------------------|--|---------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial |  | 23b. DATE<br>June 14 1979 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Memorial Gardens |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Waldorf Charles Md. |  |
|-----------------------------------------------------|--|---------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------------------|--|

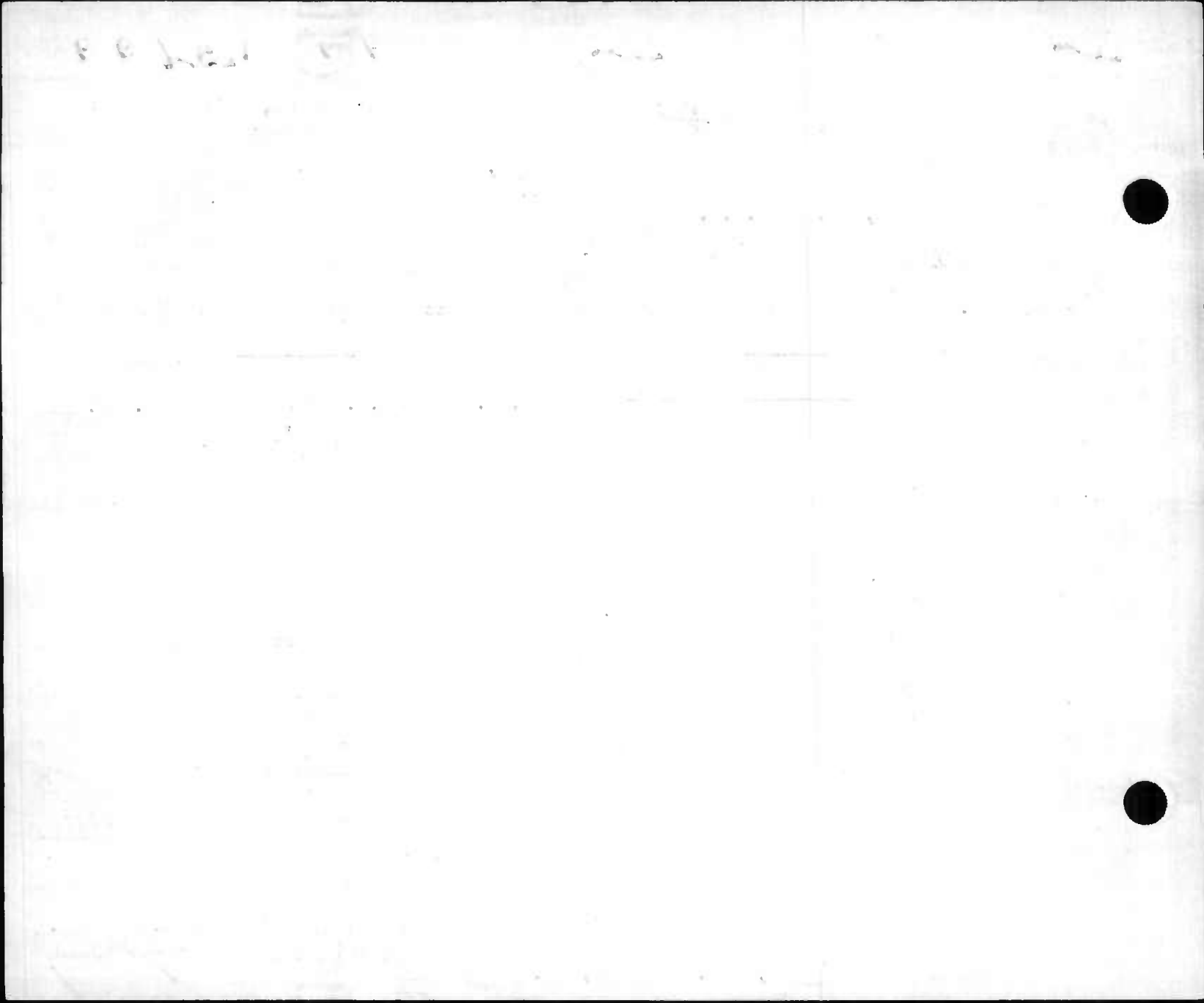
|                                                                                        |  |                                                |  |                                               |  |
|----------------------------------------------------------------------------------------|--|------------------------------------------------|--|-----------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Archart Funeral Home, Inc. La Plata, Md. 20646 |  | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 18 1979 |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCurdy |  |
|----------------------------------------------------------------------------------------|--|------------------------------------------------|--|-----------------------------------------------|--|

|        |  |                                 |  |
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| 26. BP |  | DMMH-16 20M<br>(VRA 15, 4) 7/78 |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14800

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |               |  |                                              |  |  |  |                                         |  |                                                                                                                                   |  |                                         |  |                                     |  |  |  |                   |  |                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|----------------------------------------------|--|--|--|-----------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|-------------------------------------|--|--|--|-------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                       |  |               |  |                                              |  |  |  |                                         |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 10 19 79                                   |  |                                         |  |                                     |  |  |  |                   |  | 2b. HOUR 12:22 AM                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Oscar Andrew Wright Jr.                                                                                                                                                                                                                                                                                                                                                               |  |               |  |                                              |  |  |  |                                         |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.                                                                             |  |                                         |  |                                     |  |  |  |                   |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.                                                                                          |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.     |  |  |  |  |  |  |  |  |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE Black |  | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 10, '53 |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                             |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |  | 7c. DATE PRONOUNCED DEAD 6 10 19 79 |  |  |  | 14. HOUR 12:22 AM |  |                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |  |               |  |                                              |  |  |  |                                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU) |  |                                         |  |                                     |  |  |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONRAIL                                                          |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY TRACKMAN                                                                                                               |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 13a. STATE MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                      |  |               |  |                                              |  |  |  |                                         |  | 13b. COUNTY BALTIMORE                                                                                                             |  |                                         |  |                                     |  |  |  |                   |  | 13c. CITY OR TOWN BALTIMORE                                                                                                    |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS 1240 NORTHVIEW ROAD                      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST OSCAR A.                                                                                                                                                                                                                                                                                                                                                                                             |  |               |  |                                              |  |  |  |                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ERNESTINE O. WRIGHT                                                                    |  |                                         |  |                                     |  |  |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO.                                                         |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. -----                                                                                                                           |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS MRS. DENISE WRIGHT 1240 NORTHVIEW ROAD |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot Wound of Head<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) }<br>(c) }                                                                                                                                                             |  |               |  |                                              |  |  |  |                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                      |  |                                         |  |                                     |  |  |  |                   |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |               |  |                                              |  |  |  |                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |  |                                         |  |                                     |  |  |  |                   |  | 20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |               |  |                                              |  |  |  |                                         |  | 21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 10:07 P.M. 6 9 19 79                                                                  |  |                                         |  |                                     |  |  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot self                                |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                               |  |               |  |                                              |  |  |  |                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) In front of house                                                     |  |                                         |  |                                     |  |  |  |                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 840 Woodington Rd., Baltimore Md.                                               |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion depth resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |                                              |  |  |  |                                         |  | TITLE (SPECIFY) Assistant                                                                                                         |  |                                         |  |                                     |  |  |  |                   |  | DATE SIGNED 6/10/79                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE Margaret A. Korell                                                                                                                                                                                                                                                                                                                                                                                                      |  |               |  |                                              |  |  |  |                                         |  | M.D. Assistant MEDICAL EXAMINER                                                                                                   |  |                                         |  |                                     |  |  |  |                   |  | EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                                         |  |               |  |                                              |  |  |  |                                         |  | 23b. DATE 6/13/79                                                                                                                 |  |                                         |  |                                     |  |  |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK                                                                          |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, MARYLAND                                                                                           |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME LEROY O. DYETT & SON                                                                                                                                                                                                                                                                                                                                                                                           |  |               |  |                                              |  |  |  |                                         |  | ADDRESS 4600 LIBERTY HGTS. AVE.                                                                                                   |  |                                         |  |                                     |  |  |  |                   |  | 25a. DATE REC'D. BY REGISTRAR JUN 13 1979                                                                                      |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]                                                                                                                   |  |  |  |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |

COLEMAN



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 1 4 8 0 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     |                                                                                                                                                                           |                                                                                                 |                                                                                      |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN E. WRIGHTSON</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 12, 1979</b>                                     |                                                                                      | 2b. HOUR<br>MIN.<br><b>2:55A</b>                                                                                           |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>W</b>                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-27-1899</b>                                                                                                                    |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                         |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |                                                                                                                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESLADY</b>            |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>                                                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                     |                                                                                                                                                                           |                                                                                                 |                                                                                      |                                                                                                                            |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                           | 13b. COUNTY<br><b>—</b>                                                                                                             | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>449 N. CLINTON ST.</b>                                     |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WALTER KRIEGER</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     |                                                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA NOVAK</b>                              |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-03-3301</b>                                                                                             |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>Wm W. Wrightson - 2136 Swanton Rd.</b>                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROBABLY ACUTE MYOCARDIAL INFARCTION</b> |                                                                                                                                     |                                                                                                                                                                           |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                                                                                                           |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                          |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                         |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                          |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                    |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (1) this hospital attended the deceased from <b>JUNE 11, 19 79</b> , to <b>JUNE 12, 19 79</b> , that (1) we last saw the deceased alive on <b>JUNE 12, 19 79</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)                                                                                                   |                                                                                                                                     |                                                                                                                                                                           |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><i>Walker A. Impagliatelli</i>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6-12-79</b>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALKER A. IMPAGLIATELLI, M.D.</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD</b>                                                                                     |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>ENTOMBMENT</b>                                                                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br><b>6-15-79</b>                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CRESTLAWN CEM.</b>                                                                                                               |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>State Hygiene - 2334</i>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                     | ADDRESS<br><i>Dufferin St</i>                                                                                                                                             |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1979</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey M. Gandy</i>                                                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



106419



1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 8 0 2

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                               |                                                                                                                                                                |                                                                                                          |                                                                                               |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD H. WROE</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                               |                                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 24, 1979</b>                                              |                                                                                               | 2b. HOUR<br><b>2:10p M</b>                                                                                                 |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4 RACE<br><b>White</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 12, 1916</b>                                                                                                     |                                                                                                          | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>62 yrs.</b>                                              |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>                                                                                                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                              |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer State Highway Admin.</b> |                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                   | 13b. COUNTY<br><b>Balto.</b>                                                                                                                  | 13c. CITY OR TOWN<br><b>Glyndon</b>                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 13e. STREET ADDRESS<br><b>8 Worthington Hill Dr.</b>                                          |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Philip C. Wroe</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Uthman</b>                                                                                           |                                                                                                          |                                                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>212-03-5273</b>                                                                                                                 |                                                                                                          | 17. INFORMANT<br>ADDRESS<br><b>8 Worthington Hill Dr.<br/>Janet J. Wroe Glyndon, Maryland</b> |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Bronchogenic Cancer of Lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1978</b> |                                                                                                                                               |                                                                                                                                                                |                                                                                                          |                                                                                               |                                                                                                                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                    |                                                                                                                                               |                                                                                                                                                                |                                                                                                          |                                                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                               |                                                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                              |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                             |                                                                                                                            |
| 22a. I certify that (1) <del>(XX)</del> attended the deceased from <b>6/21</b> 19 <b>79</b> , to <b>6/24</b> 19 <b>79</b> , that (1) <del>(X)</del> lost<br>saw the deceased alive on <b>6/24</b> 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>above, (1) <del>(XX)</del> did <del>(XXX)</del> view the body after death.                                               |                                                                                                                                               |                                                                                                                                                                |                                                                                                          |                                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br><b>Stuart H. Brager</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                               | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                          | 22c. DATE SIGNED<br><b>24 Jun 79</b>                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stuart H. Brager, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               | 22e. ADDRESS<br><b>c/o 1114 St. Paul Street Balto. MD 21202</b>                                                                                                |                                                                                                          |                                                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                      | 23b. DATE<br><b>June 26, 1979</b>                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Pk. Westview Monori</b>                                                                                      |                                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br><b>H. E. Ellhardt</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | ADDRESS<br><b>Owings Mills, Md.</b>                                                                                                                            |                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                           | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>                                                                      |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14803

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                                  |                                                                                                                                                          |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ADELAIDE WYNN</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 6 79</b>                |                                                                                                                                                          | 2b. HOUR<br><b>6:40</b>                                                              |                                                                                              |                                                                                                                            |                                                  |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>NEGRO</b>                                                                                                               |                                                                  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 1 24</b>                                                                                                         |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN<br><b>54</b>                       |                                                                                                                            |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTD. CITY</b> MD.                               |                                                                                                                            |                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |                                                                  |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                           |                                                                  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |                                                                                      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>2930 Baker St.</b>     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Samuel Johnson</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ruth Waters</b> |                                                                                                                                                          |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>213-26-2925</b>                                                                                        |                                                                  | 17. INFORMANT<br><b>BARBARA BRICE</b>                                                                                                                    |                                                                                      | ADDRESS<br><b>159 Colvin St.</b>                                                             |                                                                                                                            |                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4/51 Pulmonary Emboli</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                            |  |                                                                                                                                       |                                                                  |                                                                                                                                                          |                                                                                      |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                                                              |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____<br><b>Gastrointestinal bleeding</b>                                                                                                                                                                                            |  |                                                                                                                                       |                                                                  |                                                                                                                                                          |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
| 19a. DATE OF OPERATION<br><b>no.</b>                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                                                                  |                                                                                                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                             |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>                                                               |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 27</b> , 19 <b>79</b> , to <b>June 6</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>June 6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |                                                                  |                                                                                                                                                          |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
| 22b. SIGNATURE<br><b>Chaya Chansanchal</b>                                                                                                                                                                                                                                                                                                                               |  | DEGREE<br><b>MD</b>                                                                                                                   |                                                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |                                                                                      | 22c. DATE SIGNED<br><b>6/6/79</b>                                                            |                                                                                                                            |                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARAYA CHANSANCHAL</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       | 22e. ADDRESS<br><b>Lutheran Hospital.</b>                        |                                                                                                                                                          |                                                                                      |                                                                                              |                                                                                                                            |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>6/11/79</b>                                                                                                           |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEM.</b>                                                                                             |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                              |                                                                                                                            |                                                  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |                                                                  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                     |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                          |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzpatrick</b> |  |

00141



Handwritten signature or initials in the bottom left corner.

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                               |                                                               |                                                                                |                                   |                                                                     |  |                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------|--|-------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 20. DATE OF DEATH                                                                                                                             |                                                               | 21. HOUR                                                                       |                                   | 22. MONTH                                                           |  | 23. YEAR                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 20. DATE OF DEATH                                                                                                                             |                                                               | 21. HOUR                                                                       |                                   | 22. MONTH                                                           |  | 23. YEAR                            |  |
| CHARLIE YANCEY                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 6 21 79                                                                                                                                       |                                                               | 10:50 PM                                                                       |                                   |                                                                     |  |                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                              |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                   | 7. IF UNDER 1 YEAR                                                  |  | 8. IF UNDER 24 HRS                  |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Black                                                                                                  | 9 6 05                                                                                                                                        |                                                               | 73 YRS                                                                         |                                   | MONTHS                                                              |  | DAYS                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                   |                                                                     |  |                                     |  |
| Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                        | U.S.A.                                                                                                 |                                                                                                                                               |                                                               | Baltimore City                                                                 |                                   |                                                                     |  |                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                     |  |                                     |  |
| Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Good Samaritan Hosp.                                                                                   |                                                                                                                                               | Construction worker                                           |                                                                                |                                   |                                                                     |  |                                     |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 13b. COUNTY                                                                                                                                   |                                                               | 13c. CITY OR TOWN                                                              |                                   | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                 |  |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                               |                                                               | Balto                                                                          |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1635 Monroe St.                     |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                      |                                                               | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)               |                                   | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT ADDRESS               |  |
| Robert Yancey                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | Jennie Jones                                                                                                                                  |                                                               | NO                                                                             |                                   | 220-09-6183                                                         |  | Mrs. Janie Yancey 1635 V. Monroe St |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatic failure</u>                                                                                                                                                                                               |                                                                                                        |                                                                                                                                               |                                                               |                                                                                |                                   |                                                                     |  |                                     |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hepatic failure</u>                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                               |                                                               |                                                                                |                                   |                                                                     |  |                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                               | 20a. AUTOPSY?                                                                  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                               |                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                              |                                                                                                        | 21b. TIME OF INJURY - HOUR A.M. MONTH DAY YEAR                                                                                                |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |                                                                     |  |                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | P.M. 19 79                                                                                                                                    |                                                               |                                                                                |                                   |                                                                     |  |                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |                                                                     |  |                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                               |                                                               |                                                                                |                                   |                                                                     |  |                                     |  |
| 22. I certify that (this hospital) attended the deceased from <u>May 12</u> 19 <u>79</u> to <u>June 21</u> 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>June 21</u> 19 <u>79</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input type="checkbox"/> not view the body after death. |                                                                                                        |                                                                                                                                               |                                                               |                                                                                |                                   |                                                                     |  |                                     |  |
| 22a. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 22b. DEGREE                                                                                                                                   |                                                               | 22c. DATE SIGNED                                                               |                                   |                                                                     |  |                                     |  |
| Dan Morton                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                               |                                                               | 6/21/79                                                                        |                                   |                                                                     |  |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 22e. ADDRESS                                                                                                                                  |                                                               | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                      |                                   | 23b. DATE                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| DAN MORTON MD                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 5601 Loch Raven Blvd.                                                                                                                         |                                                               | Burial                                                                         |                                   | 6-29-79                                                             |  | First Baptist Church                |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 24b. ADDRESS                                                                                                                                  |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                  |                                   | 25b. REGISTRAR'S SIGNATURE                                          |  |                                     |  |
| Joseph L. Russ                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 2222 W. North Ave.                                                                                                                            |                                                               | JUL 2 1979                                                                     |                                   |                                                                     |  |                                     |  |

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added info g534 8/16/79 gj

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 8 0 5

|                                                                                                                                                                                                                                  |  |                  |                                                                                                                                                                                                                                                                                                                                                                                   |                                               |                                                           |                                                                                                                                                          |  |                                                                                                                            |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>YOUNG BB BONNIE                                                                                                                                                                           |  |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 18 79                                                                                                                                                                                                                                                                                                                                    |                                               |                                                           | 2b. HOUR<br>2-45 AM                                                                                                                                      |  |                                                                                                                            |                                                                                      |  |
| 3. SEX<br>M                                                                                                                                                                                                                      |  | 4. RACE<br>Black |                                                                                                                                                                                                                                                                                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 17 79 |                                                           | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS. MONTHS DAYS<br>4 29                                                                                            |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS                                                                                         |                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                            |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                               |                                               |                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                           |  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BCH                                                                                                                                                                                                                                                                  |                                               |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>—                                                                                    |  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                                               |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                           |  |                  | 13b. COUNTY<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                          |                                               |                                                           | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                           |  |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>— — —                                                                                                                                                                                  |  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bonnie Young                                                                                                                                                                                                                                                                                                                     |                                               |                                                           | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                     |  |                                                                                                                            | 16b. SOCIAL SECURITY NO.                                                             |  |
| 17. INFORMANT<br>ADDRESS                                                                                                                                                                                                         |  |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u><br>769-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>respiratory distress syndrome</u> |                                               |                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                                                                            |                                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                               |  |                  |                                                                                                                                                                                                                                                                                                                                                                                   |                                               |                                                           |                                                                                                                                                          |  |                                                                                                                            |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                           |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                  |                                               |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                            |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                        |                                               |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                            |                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                     |  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                            |                                               |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |                                                                                                                            |                                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/17/79</u> , 19 <u>79</u> , to <u>6/18/79</u> , 19 <u>79</u> , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. |  |                  |                                                                                                                                                                                                                                                                                                                                                                                   |                                               |                                                           |                                                                                                                                                          |  |                                                                                                                            |                                                                                      |  |
| 22b. SIGNATURE<br>Smehta                                                                                                                                                                                                         |  |                  | DEGREE                                                                                                                                                                                                                                                                                                                                                                            |                                               |                                                           | 22c. DATE SIGNED                                                                                                                                         |  |                                                                                                                            |                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAROT MEHTA                                                                                                                                                                             |  |                  | 22e. ADDRESS<br>BCH                                                                                                                                                                                                                                                                                                                                                               |                                               |                                                           | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                     |  |                                                                                                                            |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                           |  |                  | 23b. DATE<br>6-18-79                                                                                                                                                                                                                                                                                                                                                              |                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore City Hosp |                                                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |                                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                     |  |                  | ADDRESS                                                                                                                                                                                                                                                                                                                                                                           |                                               |                                                           | 25a. DATE REC'D. BY REGISTRAR<br>JUL 16 1979                                                                                                             |  |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>Anthony M. Bradley                                     |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COPIES





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR Items 19b. & 21a. - 21f                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  | STATE OF MARYLAND                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                    |  |
| Film#G533 7-23-79 as                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  | CERTIFICATE OF DEATH                                                                                       |  |
| REG. NO.                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | 1 4 8 0 6                                                                                                  |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |  | FIRST <b>Louise</b> MIDDLE <b>-</b> LAST <b>Yox</b>                                                                             |  | 2a DATE OF DEATH - MONTH DAY YEAR 2b HOUR P.M.                                                             |  |
| 3 SEX <b>female</b>                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE <b>white</b>                                                                                                             |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>8-24-98</b>                                                              |  |
| 6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b>                                                                                                                                                                                                                                                                                                                       |  | 7b BIRTHPLACE (COUNTRY) <b>Balto., Maryland</b>                                                                                 |  | 8 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                  |  |
| 7a BIRTHPLACE (COUNTRY) <b>Balto., Maryland</b>                                                                                                                                                                                                                                                                                                                |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                       |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                                              |  |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                      |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>                              |  |
| 13a STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                      |  | 13b CITY OR TOWN <b>Baltimore</b>                                                                                               |  | 13c STREET ADDRESS <b>1036 Lakemont Road 1222-706WELL-AVE.</b>                                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>ADOLPH KLINGELHOFFER</b>                                                                                                                                                                                                                                                                                                 |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN Mary Theresa Wess</b>                                                      |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                 |  |
| 16b SOCIAL SECURITY NO. <b>213-74-1759</b>                                                                                                                                                                                                                                                                                                                     |  | 17 INFORMANT <b>William F. Boglitsch</b>                                                                                        |  | 18 ADDRESS <b>Catonsville, Md. 21228. 1036 Lakemont Rd.</b>                                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4289</b> IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b>                                                                                                                                                                                                    |  |                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                               |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC CARDIAC FAILURE</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  |                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                           |  |                                                                                                                                 |  |                                                                                                            |  |
| 19a DATE OF OPERATION <b>5-26-79</b>                                                                                                                                                                                                                                                                                                                           |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured Hip Rem &amp; reinsert. nailing</b>                                |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5 12 79</b>                                                                      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Fall in Nursing home.</b> |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                               |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N.H.</b>                                                  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>                                         |  |
| 22a I certify that (X) this hospital attended the deceased from <b>5-25-79</b> , 19 <b>79</b> , to <b>5/29/79</b> , 19 <b>79</b> , that (X) (we) lost saw the deceased alive on <b>5/29</b> , 19 <b>79</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (we) (did) not view the body after death. |  |                                                                                                                                 |  |                                                                                                            |  |
| 22b SIGNATURE <b>Dr. Victor William Cheloliber MD</b>                                                                                                                                                                                                                                                                                                          |  | DEGREE <b>MD</b>                                                                                                                |  | 22c DATE SIGNED <b>5/29/79</b>                                                                             |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>VICTOR V. CHELOLIBER MD</b>                                                                                                                                                                                                                                                                                            |  | 22e ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>                                                                          |  |                                                                                                            |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                         |  | 23b DATE <b>6/1/79</b>                                                                                                          |  | 23c NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery - Baltimore, Md.</b>                             |  |
| 24 FUNERAL DIRECTOR NAME <b>Stirling Funeral Estate</b>                                                                                                                                                                                                                                                                                                        |  | ADDRESS <b>736 Edmondson Ave. Catonsville, Md. 21228</b>                                                                        |  | 25a DATE REC'D. BY REG. CLERK <b>JUN 4 1979</b>                                                            |  |
| 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |  |                                                                                                            |  |

BP



BALTIMORE CITY

1036 Lakewood Road  
Baltimore, Md. 21229

ST. AGNES HOSPITAL

BALTIMORE

1036 Lakewood Road  
Baltimore, Md. 21229

1036 Lakewood Road

BALTIMORE

1036 LAKWOOD AVE. BALTIMORE, MD. 21229

1036 LAKWOOD AVE. BALTIMORE, MD.

BALTIMORE

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14807

|                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                |                                                                                                                                                             |                                                                             |                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NICK ZARZESKI                                                                                                                                                                                                                                                                                            |                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 25, 1979                        |                                                                                                 | 2b. HOUR<br>4:10P                                                                                                          |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>WHITE                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 13-1925                                                                                                             |                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD                                           |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTO                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hosp. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SOLDIER | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Army                                                  |                                                                                                                            |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>BALTO                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2209 Gough ST.                                                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>WIKOWSKI                                                                                                   |                                                                             |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                          |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>WILL<br>612-18-302                                                                                                              | 17. INFORMANT<br>ADDRESS<br>MARGARET SEYMAROWSKI<br>2209 Gough ST           |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF COLON<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                |                                                                                                                                                             |                                                                             |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                  |                                                                                                                                |                                                                                                                                                             |                                                                             |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                         |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (1) this person attended the deceased from JUNE 14, 1979 to JUNE 25, 1979, that (1) we lost saw the deceased alive on above, (1) and that (did not) view the body after death.                                                                                                                                                                   |                                                                                                                                |                                                                                                                                                             |                                                                             |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>S. P. GIRDHAR                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                             | 22c. DATE SIGNED<br>6-25-79                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. P. GIRDHAR, M.D.                                                                                                                                                                                                                                                                                                         |                                                                                                                                | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD                                                                               |                                                                             |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br>6-28-79                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART                                                                                                          |                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                                          |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOHN M. WEBER & SONS INC, CHESTER                                                                                                                                                                                                                                                                                                    |                                                                                                                                | ADDRESS<br>401 S                                                                                                                                            |                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                    | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.                                                                                  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 8 0 8

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |                                                            |                                                                                                                                                             |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Romayne B. Zeigman</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 4, 1979</b> |                                                                                                                                                             | 2b. HOUR<br><b>9 A. M.</b> |                                                                                                                                            |  |                                                                                                                            |     |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 11, 1903</b>                                                                                                |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>75</b>                                                                                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                                                              |  |                                                                                                                            | MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3939 Roland Avenue Apt 419</b> |                                                            |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Bank Teller</b>                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b>                                                                        |     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                                    |                                                            | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br><b>3939 Roland Ave. Apt 419</b>                                                                     |     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles M. Hare</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie N. Shock</b>                                                                                     |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>215 01 6278A</b>                                                                                                |                                                            | 17. INFORMANT<br>ADDRESS<br><b>Helen Lucas 1307 W. 40th Street 21211</b>                                                                                    |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3989 Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Rheumatic arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>disease</b> |  |                                                                                                                                                |                                                            |                                                                                                                                                             |                            |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 years</b><br><b>25 years</b>                                         |     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Bilateral mastectomies for cancer (1961/1978)</b>                                                                                                                                                                                                                               |  |                                                                                                                                                |                                                            |                                                                                                                                                             |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                            |                                                                                                                                                             |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 22a. I certify that (i) this hospital attended the deceased from <b>19 Sept. 1963</b> to <b>June 4, 1979</b> , that (ii) <del>the</del> <b>may 14, 1979</b> saw the deceased alive on <b>may 14, 1979</b> and that in (my) <del>an</del> <b>opinion</b> death occurred on the date and hour and from the causes stated above. (If <del>the</del> <b>my</b> did not view the body after death)                             |  |                                                                                                                                                |                                                            |                                                                                                                                                             |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 22b. SIGNATURE<br><b>Marvin Goldstein, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |                                                            | DEGREE<br><b>M.D.</b>                                                                                                                                       |                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/5/79</b>                                                                                          |     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Marvin Goldstein</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |                                                            | 22e. ADDRESS<br><b>6001 Park Heights Avenue</b>                                                                                                             |                            |                                                                                                                                            |  |                                                                                                                            |     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>June 6, 1979</b>                                                                                                               |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Saters Cemetery</b>                                                                                                |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lutherville/Tim. Balto. Co. Md.</b>                                                       |  |                                                                                                                            |     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee Funeral Home 3631 Falls Rd. 21211</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                                                          |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Barney K. Kinsky</b>                                                                                      |  |                                                                                                                            |     |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14809

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KATHERINE DOROTHY ZEPP0</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 23 79</b> |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>9:30AM</b>                                                                       |                                                                                                                               |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>W</b>                                                                                                                 |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-15-1922</b>                                                                                                      |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                               |                                                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTA</b>                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |                                                       |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITRESS</b>             |                                                                                                                               |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>—</b>                                                                                                             |                                                       | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                                                                                          |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |  |
| 13e. STREET ADDRESS<br><b>427 N. MONTFORD AVE</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>— MOORE</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>130-22-3235</b>                                                       |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Juanita Swisher - 431 N. Montford Ave.</b>                                                                              |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b><br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA - PRIMARY UNKNOWN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b>                                           |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>—</b>                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |                                                       |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                   |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>                                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>                                                  |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— BALTO. MD.</b>                                                                                    |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 10</b> , 19 <b>79</b> , to <b>JUNE 23</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>JUNE 23</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>George Karkar</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                                                                                      | 22c. DATE SIGNED                                                                                |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE KARKAR</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                       | 22e. ADDRESS<br><b>CHURCH HOSPITAL, BALTIMORE, MARYLAND</b>                                                                                                 |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>6-26-79</b>                                                                                                         |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER</b>                                                                                                  |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                                 |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Barclay Miller 2334 Jefferson St.</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Barclay Miller</b>                                             |                                                                                                                               |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 14810

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  |  | FIRST MIDDLE LAST                                                                                      |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                        |  |  | 2b. HOUR                                                            |  |  |
| Beulah Alice Zerbola                                                                                                                                                                                                                                                                                |  |  |                                                                                                        |  |  | June 9, 1979                                                                                                                                            |  |  | 10:45 P                                                             |  |  |
| 3 SEX                                                                                                                                                                                                                                                                                               |  |  | 4 RACE                                                                                                 |  |  | 5 DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |  |
| Female                                                                                                                                                                                                                                                                                              |  |  | White                                                                                                  |  |  | June 13, 1893                                                                                                                                           |  |  | 85 YRS                                                              |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                           |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |
| Maryland                                                                                                                                                                                                                                                                                            |  |  | U.S.A.                                                                                                 |  |  |                                                                                                                                                         |  |  | Baltimore City MD                                                   |  |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                            |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Baltimore                                                                                                                                                                                                                                                                                           |  |  | Hamilton Nursing Center                                                                                |  |  | Housewife                                                                                                                                               |  |  |                                                                     |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                          |  |  | 13b. COUNTY                                                                                            |  |  | 13c. CITY OR TOWN                                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS?                                            |  |  |
| Maryland                                                                                                                                                                                                                                                                                            |  |  |                                                                                                        |  |  | Baltimore                                                                                                                                               |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                              |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                       |  |  | 16b. SOCIAL SECURITY NO.                                            |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  | White                                                                                                  |  |  | No                                                                                                                                                      |  |  | 217-46-2057                                                         |  |  |
| 17 INFORMANT                                                                                                                                                                                                                                                                                        |  |  | ADDRESS                                                                                                |  |  | 18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)                                       |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| Edward B. Lewis                                                                                                                                                                                                                                                                                     |  |  | 2809 Summit Ave.                                                                                       |  |  | 4029                                                                                                                                                    |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                           |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  | (c)                                                                                                                                                     |  |  |                                                                     |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                  |  |  |                                                                                                        |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |  | 20a. AUTOPSY?                                                                                                                                           |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                     |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  | P.M. 19                                                                                                |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                              |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/23/79 to 6/9/79, that (I) (we) last saw the deceased alive on 5/23/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |                                                                                                        |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                      |  |  | DEGREE                                                                                                 |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  | 22c. DATE SIGNED                                                    |  |  |
| Donald W. Mintzer, M.D.                                                                                                                                                                                                                                                                             |  |  | MD                                                                                                     |  |  |                                                                                                                                                         |  |  | 6/12/79                                                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                               |  |  | 22e. ADDRESS                                                                                           |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                     |  |  | 3009 Evergreen Ave. Baltimore, Maryland                                                                |  |  |                                                                                                                                                         |  |  |                                                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                           |  |  | 23b. DATE                                                                                              |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |
| Burial                                                                                                                                                                                                                                                                                              |  |  | June 13, 1979                                                                                          |  |  | Lorraine Park                                                                                                                                           |  |  | Baltimore Maryland                                                  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                   |  |  |                                                                                                        |  |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  |  | 25b. REGISTRAR'S SIGNATURE                                          |  |  |
| Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                           |  |  |                                                                                                        |  |  | JUN 13 1979                                                                                                                                             |  |  | Fitzroy McBrady                                                     |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01010



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14811

|                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                                               |                                                                                                                                                             |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                                                                |                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUISE EVA ZIEFLE</b>                                                                                                                                                                                                                                                        |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 29, 1979</b>                   |                                                                                                                                                             |                                       | 2b. HOUR P<br><b>4:15 M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                |                                                      |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                                |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 21, 1892</b>                                                                                                |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.               |                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                           |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                |                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>22 S. Athol Avenue</b> |                                                                               |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                      |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 13b. COUNTY<br><b>Baltimore</b>                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                | 13e. STREET ADDRESS<br><b>1019 St. Dunstons Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Hahn</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaretha Schieilitz</b> |                                                                                                                                                             |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                |                                                      |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-22-3012</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        | 17. INFORMANT<br><b>General German Aged Home</b>                              |                                                                                                                                                             |                                       | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Broncho pneumonia</b><br>(c) <b>degenerative heart disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Senility &amp; malnutrition</b> |                                                                                                 |                                                                                |                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 |                                                                                |                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                                                                |                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                                                                |                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 77</b> to <b>29 June 19 79</b> , that (I) (we) lost saw the deceased alive on <b>29 June 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                        |                                                                               |                                                                                                                                                             |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                                                                |                                                      |  |
| 22b. SIGNATURE<br><b>William J. Bryon M.D.</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                               | 22c. DATE SIGNED<br><b>29 June 79</b>                                                                                                                       |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William J. Bryon M.D.</b>          |                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                                               | 23b. DATE<br><b>7/3/79</b>                                                                                                                                  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Baltimore, Md.</b> |                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Witzke Catonsville Funeral Home, P.A. 21228</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                                               | 25. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                           |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Ernest K. Hardy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                |                                                      |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RIGHTS

REPORT

NO. 1

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Water Right No. 1

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Water Right No. 1

Water Right No. 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  |                                                                                                                                                             |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       | REG. NO. 14812                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <b>CHARLES</b> MIDDLE <b>GALEN</b> LAST <b>ZILE</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 25, 1979</b>                                     |                                                                                     |                                                     | 2b. HOUR<br><b>12<sup>30</sup> A.M.</b>                                                                                 |                                                       |                                              |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Caucasian</b>                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 6 13</b>                                                                                                           |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                   |                                                     | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |                                                       |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Md City MD</b>                 |                                                     |                                                                                                                         |                                                       |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |                                                                                                                                                             |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance</b> |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State Roads</b>                                                                 |                                                       |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. CITY OR TOWN <b>New Windsor</b> 13c. COUNTY <b>Carroll</b>                                                                                                                                                                                                                           |  |                                                                                                                                      |  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     | 13e. STREET <b>2430 Marston Road</b>                |                                                                                                                         |                                                       |                                              |  |
| 14. FATHER'S NAME FIRST <b>Carroll</b> MIDDLE <b>-</b> LAST <b>Zile</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Edith</b> MIDDLE <b>-</b> LAST <b>Grossnickle</b>                                                                         |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes - World War II</b>                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>218-18-9186</b>                                                                                       |  | 17. INFORMANT ADDRESS<br><b>Mrs. Helen Bostian, New Windsor, Md.</b>                                                                                        |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhagic Shock</b><br><b>4413</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ruptured Abdominal Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                      |  |                                                                                                                                                             |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  |                                                                                                                                                             |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 19a. DATE OF OPERATION<br><b>6/24/79</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Abdominal Aortic Aneurysm</b>                                        |  |                                                                                                                                                             |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>              |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                       |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             |                                                                                              |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 22b. SIGNATURE<br><b>Kevin James Farrell</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  |                                                                                                                                                             | DEGREE<br><b>M.D.</b>                                                                        |                                                                                     |                                                     | 22c. DATE SIGNED<br><b>6/25/79</b>                                                                                      |                                                       |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kevin James Farrell</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  |                                                                                                                                                             | 22e. ADDRESS<br><b>Baltimore, Maryland University Hospital</b>                               |                                                                                     |                                                     |                                                                                                                         |                                                       |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>6/27/1979</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Pauls Cemetery</b>                                                                                             |                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arcadia, Maryland</b>                 |                                                     |                                                                                                                         |                                                       |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br><b>W. J. Hantzler</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  |                                                                                                                                                             | ADDRESS<br><b>New Windsor, Md.</b>                                                           |                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b> |                                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b> |                                              |  |

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FILE

CLASS

CLASS

LOCATION

X

M. S.

Baltimore

24-30 24-30 24-30

X

24-30 24-30 24-30

24-30 24-30 24-30

Yes - World War II 24-30 24-30 24-30

Baltimore, Maryland  
University Hospital

24-30 24-30 24-30

New Windsor, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 8 1 3

|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                |                                                                                                                                                             |                                                                                                       |                                                                                                                            |                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>PEGGY ANN ZIMERNACK                                                                                                                                                                                                                                                                                       |                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 9 79                                                      |                                                                                                                            | 2b. HOUR<br>7:01P <sub>M</sub>                 |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>White                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 3 1947                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>32<br>YRS                                                          | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>8. UNDER 24 HRS<br>HOURS MIN                                                             |                                                |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto                                                                                                                                                                                                                                                                                                                    | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                            |                                                                                                                            |                                                |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>Advertising                                                                           |                                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                     | 13b. COUNTY<br>A.A. Co.                                                                                                        | 13c. CITY OR TOWN<br>Severn                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       | 13e. STREET ADDRESS<br>8322 Ches Mar Ct.                                                                                   |                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Wallace Ferrin                                                                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Elizabeth McDairmant                                                  |                                                                                                                                                             | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |                                                                                                                            |                                                |
| 16b. SOCIAL SECURITY NO.<br>218 46 5358                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 17. INFORMANT<br>ADDRESS<br>Frances E. Ferrin 1051 Church St.                                                                                               |                                                                                                       |                                                                                                                            |                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CIRRHOSIS AND FATTY CHANGE</u><br>5715- DUE TO, OR AS A CONSEQUENCE OF <u>OF LIVER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                |                                                                                                                                                             |                                                                                                       |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                   |                                                                                                                                |                                                                                                                                                             |                                                                                                       |                                                                                                                            |                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                       |                                                                                                                            |                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                       |                                                                                                                            |                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                           |                                                                                                                                |                                                                                                                                                             |                                                                                                       |                                                                                                                            |                                                |
| 22b. SIGNATURE<br>BERT F. MORTON                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                |                                                                                                                                                             | DEGREE<br>M.D.                                                                                        | 22c. DATE SIGNED<br>06-10-79                                                                                               |                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERT F. MORTON                                                                                                                                                                                                                                                                                                               |                                                                                                                                |                                                                                                                                                             | 22e. ADDRESS<br>ST AGNES HOSPITAL<br>900 CATON AVE. BALTIMORE, MD. 21229                              |                                                                                                                            |                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                | 23b. DATE<br>6/13/79                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem                                                                                                       |                                                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                |                                                |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | ADDRESS<br>Balto 21225                                                                                                                                      |                                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>JUN 14 1979                                                                               | 25b. REGISTRAR'S SIGNATURE<br>Rita J. McCreedy |

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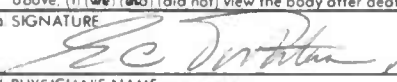
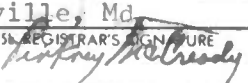
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7 9 1 4 8 1 4<br>REG. NO.                                                                                                                  |  |                                                                                                                                                             |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mildred F. ZIMMERMAN</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                             | 2. DATE OF DEATH MONTH DAY YEAR<br><b>June 25, 1979</b> |                                                                                                                                            |  |                                                                                                                            |                                                                 | 7b. HOUR<br><b>8:35AM</b> |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>W</b>                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 3, 1900</b>                                                                                                      |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                                                                           |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                                                   |                                                                 |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                          |  |                                                                                                                            |                                                                 |                           |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |                                                                                                                                                             |                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b>                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Import Shop</b>                                                                    |                                                                 |                           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>---</b>                                                                                                                  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br><b>108 W. 39th St.</b>                                                                              |                                                                 |                           |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Briel</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sophie Disher</b>                                                                                          |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>212 30 3561</b>                                                                 |  | 17. INFORMANT ADDRESS<br><b>Mr. George F. Zimmerman 108 W. 39th St.</b>                                                                                     |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         |                                                                                                                                            |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 Hour</b> |                           |
| 1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>Disseminated Carcinoma Of Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive Heart Failure</b>                                                                                                                                                                                                               |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Disseminated Cancer, Congestive Cardiac Failure</b>                                                                                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                             |                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 22a. I certify that (I) ( <del>was present</del> ) attended the deceased from <b>June 12</b> , 19 <b>79</b> , to <b>June 25</b> , 19 <b>79</b> , that I <del>xxx</del> last saw the deceased alive on <b>June 25</b> , 19 <b>79</b> , and that in (my) <del>xxx</del> opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>do</del> ) ( <del>did not</del> ) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         |                                                                                                                                            |  |                                                                                                                            |                                                                 |                           |
| 22b. SIGNATURE  DEGREE                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-25-79</b>                                                                                         |                                                                 |                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edmund C. Tortolani, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                       |  |                                                                                                                            |                                                                 |                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>6/28/79</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                                                                                           |                                                         | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>                                                                          |  |                                                                                                                            |                                                                 |                           |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                                                             |                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br>        |                                                                 |                           |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

14815

|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE</b>                                                                                                                                                                                                                                                                                                                              |  | FIRST<br>MIDDLE<br>LAST<br><b>ZORN</b>                                                                                             |  | 2a. DATE OF DEATH<br>MONTH<br>DAY<br>YEAR<br><b>06-25-79</b>                                                                                                |  | 2b. HOUR<br>MIN.<br><b>12:55 P</b>                                                                                         |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>WHITE</b>                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH<br>DAY<br>YEAR<br><b>03 - 10 - 20</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b><br>YRS.                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook-Meals on Wheels</b>                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                    |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Seamon</b><br>MIDDLE<br>LAST<br><b>Vernatter</b>                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Josie</b><br>MIDDLE<br>LAST<br><b>Olaker</b>                                               |  | 13e. STREET ADDRESS<br><b>2905 Cornwall Road</b>                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>298-22-7589</b>                                                                                     |  | 17. INFORMANT<br><b>Jean Scarpulla</b>                                                                                                                      |  | ADDRESS<br><b>2902 Yorkway<br/>Balto. MD 21222</b>                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA - LUNG</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                    |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                                                                                  |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>06-15-79</b> to <b>06-25-79</b> , that (I) (we) lost<br>saw the deceased alive on <b>06-25-79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                               |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Cesar G. Gamboa, MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                             |  |                                                                                                                                    |  | 22c. DATE SIGNED<br><b>06-25-79</b>                                                                                                                         |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR G. GAMBOA, MD.</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 22e. ADDRESS<br><b>40 SINAI HOSPITAL</b>                                                                                                                    |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>6/29/79</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br><b>Bel Air, Harford, MD</b>                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br>ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |



Handwritten text at the bottom left, possibly a signature or date.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 14816

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JULIA A ZORN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           | 2a. DATE OF DEATH MONTH DAY YEAR <b>6/8/79</b>                                                                                                              |                                                                                    | 2b. HOUR <b>12<sup>05</sup> A.M.</b>                                                            |                                                            |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>White</b>                                                                   | 5. DATE OF BIRTH<br><b>7-7-1895</b>                                                                                                                         | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b>                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |                                                                                                 |                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Baltimore City Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Glen L. Martin</b> |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Balto.</b>                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            |
| 14. FATHER'S NAME<br>FIRST <b>Ernest</b> MIDDLE <b>Schultz</b> LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Dorothea</b> MIDDLE <b>Laser</b> LAST                                                                                  |                                                                                    |                                                                                                 |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>215-05-4084</b>                                                                                                              |                                                                                    | 17. INFORMANT<br>ADDRESS <b>21214</b><br><b>Mrs. Mildred Lynch - 6077 Harford Rd. -</b>         |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>4271<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular tachycardia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Organic heart disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>35 min</b><br><b>45 min</b><br><b>5 years</b> |                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)<br><b>lung disease - (obstructive)</b>                                                                                                                                                                                                                                                                                                                                        |                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                            |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                            |
| 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           | 21e. LOCATION<br>(STREET) CITY OR TOWN COUNTY STATE<br><b>Balto</b>                                                                                         |                                                                                    |                                                                                                 |                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/7/79</b> 19 to <b>6/8/79</b> 19 that (I) (we) last saw the deceased alive on <b>6/9/79</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                     |                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                            |
| 22b. SIGNATURE<br><b>E. Dudek</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                                                                                                                             |                                                                                    | 22c. DATE SIGNED<br><b>6/8/79</b>                                                               |                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. DUDEK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                                                                                                                             |                                                                                    | 22e. ADDRESS<br><b>Balto City Hosp.</b>                                                         |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           | 23b. DATE<br><b>6-11-79</b>                                                                                                                                 |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Morland Memorial Park</b>                              |                                                            |
| 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           | 24. FUNERAL DIRECTOR<br>NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b> ADDRESS                                                                        |                                                                                    |                                                                                                 |                                                            |
| 25a. DATE REG'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                            |                                                                                    |                                                                                                 |                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

